S. HRG. 110–24

HEALTH CARE COVERAGE AND ACCESS: CHALLENGES AND OPPORTUNITIES

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

ON

EXAMINING THE CHALLENGES AND OPPORTUNITIES RELATING TO HEALTH CARE FOR ALL AMERICANS

JANUARY 10, 2007

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HEALTH CARE COVERAGE AND ACCESS: CHALLENGES AND OPPORTUNITIES

WEDNESDAY, JANUARY 10, 2007

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:05 a.m., in Room SD–430, Dirksen Senate Office Building, Hon. Edward M. Kennedy, presiding.

Present: Senators Kennedy, Allard, Brown, Coburn, Enzi, Hatch, Mikulski, Obama, Burr, Sanders, Roberts, Murkowski, Isakson.

OPENING STATEMENT OF SENATOR ENZI

Chairman ENZI. Would everyone please take their seats? And you are at the meeting for the unofficial passing of the gavel. Until conference has worked out everything and there's a resolution approving the new Chairmen and Ranking Members, technically I'm the Chairman, but Senator Kennedy will be chairing, and I'll just pass the gavel to him.

Chairman KENNEDY. There you go.

Chairman ENZI. And I appreciate his cooperation.

OPENING STATEMENT OF SENATOR KENNEDY

Chairman KENNEDY. Oh, how we miss you as chairman.

[Laughter.]

Senator Enzi, let me thank you, first of all. At our initial meeting here, I'd like to acknowledge the wonderful chairmanship of Senator Enzi. He's my friend and colleague. And over the period of the last 2 years, we had a remarkable opportunity to find common ground in a wide range of different issues—pension reform, many other different kinds of questions. And we have valued each other's friendship, and have our differences, but we've been able to work in a common direction. And I want to thank him for his many courtesies.

I want to, just at the outset, recognize our newer members that have joined the committee with us now.

And I'll, certainly, I think, thank Barack Obama, who's joined our committee, and has had a long time interest in a range of different issues. When he first was elected, I remember talking with Barack Obama on so many different subject matters, and he has had a lifetime of interest in young people, in older people, in education and health issues, and we're enormously thankful for his presence and his willingness to join us.

I thank Sherrod Brown, who was very much on health issues in the House, very knowledgeable. We had the chance to work together, he in the House, and we, in the Senate, on a range of different health issues. Our committee is enormously grateful that he has been willing to join us. He has spoken about issues on health and education over a lifetime of commitment. So, we are going to benefit from his insights.

Bernie Sanders, from Vermont, has been a tireless advocate of universal comprehensive health care, single-payer coverage, as well as many other kinds of issues on health and education. And we've enjoyed working together on many different items. We're grateful for his presence, and we thank him for joining with us.

Senator Murkowski, from Alaska, we met with earlier today. I don't believe she's here right now. She was the first to show up at our earlier meeting, and we're thankful for her interest and her participation.

Senator Allard, who's from the State of Colorado, has had a particular interest in the range of different areas of health care, including public health. He was a veterinarian by profession, a public health official. Our committee has a wide area of jurisdiction and responsibility in these areas. He'll be a great help to us.

Senator Coburn, as well, is a trained physician.

So, we thank all of our members, and we'll look forward to getting on with the hearing.

Our committee gets information in a wide variety of different ways, but one of the innovative ways that Senator Enzi developed over his chairmanship was to try and have a broad group of experts in a particular subject matter and to try to have an extended conversation between these individuals and the members of the committee. And this is such a hearing, this morning. It's not the end, it's the beginning. We're talking about health. We intend to do it on education next week. And we intend to do it on what is happening to the middle class, the working families of this country, the pressure that's on them. How should we think about some of the particular issues is obviously difficult because so many of these matters are cross-referenced. But, nonetheless, we intend to go in those directions while we are beginning to deal with some of the particular responsibilities of reauthorization and get to the business of No Child Left Behind, our education, some of the other particular matters, stem cell research, and minimum wage questions that are going to be on the floor. So, we have found, under Senator Enzi's chairmanship, this type of conversation to be very useful.

Rather than having the hearings on a particular approach, we're going to try, this morning, to hear from those that have represented consumers, the business community, those who have represented the health professionals, and those that have studied and been a part of the whole march to progress over a long period of time. Karen Davis has testified as long as I've been in the U.S. Senate. I'm always inspired or interested, as someone who has followed health issues, really, over a very long period of time, and many constructive suggestions for Republican and Democratic administrations, alike, that, as we move through these issues, we really try to develop some common ground for our committee and for this Congress, to really deal substantively with these issues.

Obviously, we come to these hearings with our own kinds of interests in these questions, but I'd like for us to try and sort of open this up.

I'll just take 1 minute to remind us about what is happening. That is, first of all, what we're spending on the health care. If you look, 5 years ago, we were spending $1.3 trillion, now we're spending $2.2 trillion or $2.3 trillion on the chart on the right. So, we have gone up in the amount we are spending. From 2000 to 2007, we're spending almost a trillion more dollars in health care. And yet, if you look at the total number of people that are uninsured, you find those numbers are going up. And if you ever took out the number of children in the CHIP program, it would be going up even higher. So, the indicators are all going the wrong direction. We're spending much more, and the coverage is going down rather dramatically. And we also find out, for working families, with their incomes, that the costs have come up as well. So, the indicators are all moving in directions that I think most of us can understand are all in the wrong direction, and if they continue along, given what the challenges are today, they're going to be intensified. And the anxiety will continue to increase. Every family in America today, at some time, is going to think about health care either for their children or themselves or about their parents. And we're not going to be able to answer all of these issues or questions. But, hopefully, as a result of this Congress, we can find, in this committee, some pathways to try and deal with some of those issues. And we'll hear from you this morning.

[The prepared statement of Senator Kennedy follows:]

Prepared Statement of Senator Kennedy

It is an honor to welcome the members of our committee and our distinguished witnesses to this initial session on the fundamental issue of how to help the Nation's families afford quality health care.

Following several productive roundtables convened by Senator Enzi last Congress, we are using this format today so we can allow for more discussion and to hear from a greater array of perspectives. We request that participants make very brief opening comments of no more than 3 minutes.

We have not required formal written statements, but participants are welcome to submit them if they wish to do so. The hearing record will be held open for 10 days. We will have an open discussion, while making sure that any Senator who wishes to speak will have ample opportunity to do so. In order to keep the dialogue moving, we request that all participants limit their responses to any question to 1 minute. If the need arises, we may vary the format a little to fit the discussion.

I'm grateful to Senator Enzi for his help and the help of his staff in putting this roundtable together. We look forward to continuing the bipartisan partnership that he established as Committee Chair. The Senate has not yet acted to make our committee assignments "official," but both Caucuses have made their selections. Many are returning to the committee and we welcome their continued commitment to health care. We are delighted to be joined by several

new Members—including Senators Obama, Sanders, Brown, Coburn, Murkowski and Allard.

Today's session is the first inquiry into this issue in the new Congress, but it will not be the last. In partnership with Senator Enzi, and with all our colleagues, we'll do our best to develop proposals on how best to see that the promise of this new century of the life sciences reaches all Americans.

Members of the House and Senate have a guaranteed health plan for ourselves and our families. It's time to provide the same guarantee for every man, woman and child in the Nation.

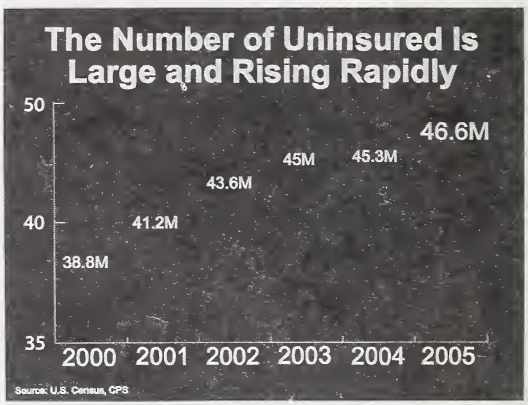
The stakes couldn't be higher. Too many trends in health care are going in the wrong direction. Insurance coverage is down. Costs are up. And America is heading to the bottom of the league of major Nations in important measures of the quality of care.

Ask people what keeps them awake most at night and many will tell you it's how to afford health care for their families.

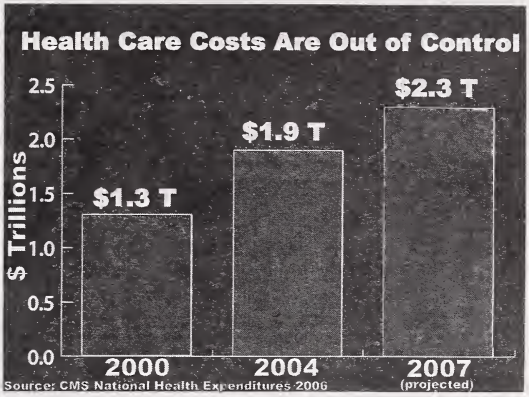
Ask companies what's high on their list of problems in trying to compete in the global economy and they'll say it's the cost of health care.

Even ask our military leaders how our troubled health care system affects recruitment and therefore our national security. They'll tell you that nearly 1 in 5 men and 2 out of 5 women of recruiting age are ineligible for military service because they're obese.

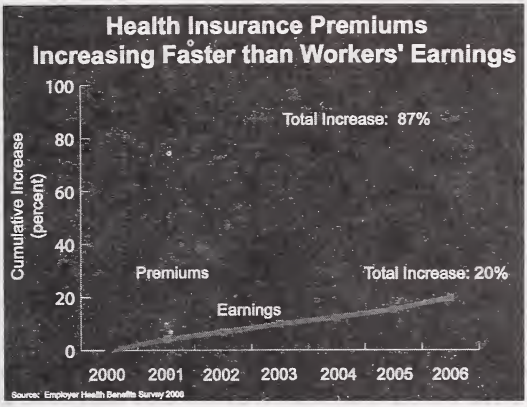
In family after family, community after community, business after business, citizens see our health care system struggling. They know that good, affordable care is less and less available.



Nearly 47 million Americans lack even basic coverage, and for tens of millions more, their coverage provides little help if major illness strikes. They often learn that truth too late, when bankruptcy results from massive bills their insurance doesn't cover. Parents struggling to save a critically ill child find themselves mortgaging their homes, maxing out their credit cards, borrowing every dime they can. Even with health insurance, they still stand to lose everything they've worked for.



Costs are obviously heading in the wrong direction. National health spending has grown from $1.35 trillion in 2000 to an estimated $2.3 trillion this year—a trillion dollars more in less than a decade. Those aren't just numbers, they're massive burdens for working families.



Health costs are threatening the livelihoods of millions of families because insurance premiums are rising four and half times faster than wages. Parents have to work longer hours and spend less time with their children, trying to keep pace with these rising costs.

Something is fundamentally wrong when our health system puts *more* stress on working families, not less. We need to find a solution in this Congress, so that every American has guaranteed access to quality care by the end of the decade.

Many of us have views on how best to address the crisis. I believe the right way is to extend the guarantee of Medicare to all Americans. Senator Enzi and others have advanced proposals to aid small businesses with the high cost of health care. Others on our committee have good ideas as well.

We should discuss all these ideas and we should pay close attention to the innovative solutions being tried in States across the country.

Last year, in Massachusetts, something remarkable happened. Patients and health professionals, business leaders and community advocates, members of the Democratic State legislature and Republican Governor Romney all rolled up their sleeves and worked together to enact a State health plan that put aside ideology and partisan divisions for the greater common good—affordable, accessible health care coverage for all the citizens of our Commonwealth.

It was fitting that the agreement reached was signed in Faneuil Hall, one of the great birthplaces of the American Revolution. In health reform, the Massachusetts plan is the shot heard 'round the country.

The same spirit of cooperation that led to our success at Faneuil Hall exists in Vermont, Illinois, Connecticut, California, and many other States across the Nation where all parts of the community are beginning to come together to find solutions to the crisis. Yesterday Governor Schwarzenegger set the admirable goal of universal coverage for the citizens of California.

We must learn that lesson here in Washington. The need for action has never been more urgent, and the consequences of failure have never been more dire. I look forward to working with the committee and with our witnesses here today to achieve the success that's become so long overdue.

Chairman KENNEDY. Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman.

And I, too, want to welcome the new members to the committee. I want to thank the old members of the committee for the tremendous cooperation and production that happened over the last 2 years. And I want to thank Senator Kennedy for his cooperation. And this roundtable is a demonstration of the continuation of what we've been doing. We want to find out as much information as possible before we make huge decisions. And one of the best ways to do that is to get a group of experts together, hear their opinions, and then have a little discourse between them. And so, I really appreciate you, first of all, getting busy so quickly, and also for using the roundtable format so that we can get that 30,000-foot perspective on the question that we're trying to deal with, which is how we can bring down health care costs. And there are going to be some more increased costs.

I know, from chairing the committee, that right now there are 654 cancer drugs that are in clinical trials, which offers a lot of hope for the future. Now, probably only a third of those will make it through clinical trials, and each of those drugs costs about a billion dollars to develop. So, two-thirds of that money is going to just go down the drain, and it will have to be picked up in some of the other drugs that do make it through the process. So, the drugs are going to be more expensive, but they'll get more results. And what we want are people to have longer, higher quality, pain-free lives. And we've got to find a mechanism for that to happen.

And, as Dr. Coburn will remind us, prevention is a good part of that. We've had some good discussions on that.

And I'm pleased to have him as the Senate's doctor, on the committee, as well as that, we also have one of the two Senate's veterans, and also someone who has served as a public health officer. All of them will lend a perspective here that will be very helpful.

I've worked to try and find some short-term solutions, and one of those has been to have market-based small business pooling across State lines. I'm from a very rural State. We don't have a big pool, to begin with. But if we can work across State lines, we thought that businesses would be able to get enough clout to be able to negotiate effectively with the big insurance companies and bring the prices down. And also, through such pooling, a big part of the savings is in administrative costs. There's the possibility of bringing the administrative cost down from 35 percent to about 12 percent, which is a huge savings on health care. And every dollar that we save in health care brings more people into the market—or at least keeps more from leaving the market. Small business is having a tremendous problem of figuring out how to do what they want to do, which is to provide good health coverage for all of their employees.

And so, hopefully, out of these discussions today at the 30,000-foot level, we can also get down to some specific areas that we can agree on. There isn't just a Republican way and a Democrat way. What we've got to do is find that third way to come up with a solution that will help the most people in this country, and hopefully, all people in this country.

Being from Wyoming, I do bring a rural approach to this, but one thing I've noticed is that every State has rural parts. In fact, even the District of Columbia thinks that there's some rural area here. I haven't found it yet, unless it's Rock Creek Park, but I'm willing to have everyone's cooperation to find the rural solutions, as well as the urban solutions. And people all live at the local level, so that's where we've got to find the solutions.

So, again, Mr. Chairman, I thank you for holding this roundtable today.

Chairman KENNEDY. Thank you very much.

What I'll do is just introduce four witnesses at a time. Our first witness is John McDonough, who's been the Executive Director of Health Care For All, and a former Massachusetts legislator. He has also been an outstanding spokesman for consumer interest in the health care system. Then we'll hear Andy Stern, President of the SEIU, who has worked hard to improve health care for employees and also to try to find some bipartisan way to work with business and other groups to try and serve workers. Larry Burton, who is the Executive Director of the Business Roundtable, can speak about the importance of business and health care. And Pat Combs, recently the broker-owner of AJS Realty, in Grand Rapids, is President of the National Association of Realtors this year. I think you understand what we're driving at. We want to hear from each of you, for 3 or 4 minutes. If you would talk about your perspectives, I think it would be helpful.

John.

STATEMENT OF JOHN McDONOUGH, EXECUTIVE DIRECTOR OF HEALTH CARE FOR ALL, BOSTON, MA

Mr. McDONOUGH. Thank you, Mr. Chairman.

My name is John McDonough. I'm Executive Director of Health Care For All. We're a consumer health advocacy organization in Massachusetts. And I want to thank both you, Senator Kennedy, and Senator Enzi, for your leadership to improve health and health care for all Americans. And thank you for the opportunity to speak here today.

I'm here as a voice for consumers. Our special interest is quality, affordable health care for all Americans. I'm also from Massachusetts. And, as you know, we've been pretty busy in Massachusetts over the past several years on the issue of expanding affordable health care.

As a result of the health reform law that was signed in Massachusetts last April 12th by Governor Romney, already today more than 80,000 Massachusetts residents who were uninsured last April now have quality, affordable health care. And by the end of February, we estimate the number will be over 100,000, and growing. So, we are on a path where we hope we will make a dramatic difference in the lives of hundreds of thousands of Massachusetts residents who go uncovered. And I have to note the important and vital contributions of Senator Kennedy in making that law happen. It would not have happened without your leadership.

So, we're neck deep in the implementation, now, of a bold and really unprecedented plan to attempt to cover all Massachusetts residents with affordable, quality coverage within a 3-year period. And many of the details of that law and that blueprint are really not transferrable. Some of them are, and many are not. But the political equation which made this law possible, we think, is something that everyone should heed and pay attention to.

The cornerstone of the new law, the bipartisan law that passed last April, is shared responsibility. And by "shared responsibility," what we mean is that solving the problem of the uninsured and the health care crisis in America requires a willingness to take on new roles and new responsibilities on the part of government, individuals, and employers. All three have to be willing to step forward and accept new responsibility. It takes all three. Two just won't do.

We are now, we believe, significantly, because of what happened in Massachusetts, in the beginning stage of a new and dynamic and hopeful period of experimentation by as many as two dozen States. And many of those States are represented around the table with the members of this committee. And we believe that there are significant opportunities, because people's ambitions have risen. People who assumed that this crisis was insoluble, that there were no new ideas, that there were no new ways to approach this, have now taken a fresh look, and we see, almost daily in the newspapers, examples from State after State who are taking a leadership role.

We think it's important that folks here in the Federal Government, much as Senator Kennedy did in Massachusetts, encourage, nurture, and support this trend of experimentation to test new ideas, to try out new approaches, to start a different kind of conversation in States that can then inform the Congress on ap-

proaches that may, in fact, be transferrable on a national level. So, this period of experimentation is a way for the members of this committee, the Members of Congress, and the whole Federal Government to have a great testing space to see what new ideas actually will crash and burn, and which ones will actually then take hold, take root, and actually then lead to new approaches to expand coverage. We are part of that. Vermont is part of that. There are a host of States right now that are vigorously engaged in this.

And so, in the meantime, I guess I would have just a couple of requests for Congress to think about, just very briefly.

First one is for us. The key challenge, the key contribution that Congress can make this year involves SCHIP and the State Children's Health Insurance Program. We hope that you can reauthorize it and expand it to the maximum extent possible. We'd invite you to think of SCHIP as a 10-year experiment which has proved its concept. It is now covering about 5 million lower-income children who would otherwise have no coverage, and yet we still have 9 million uninsured kids in the United States in need of coverage. And we would link, as you think SCHIP reauthorization, to the experimentation going on in the States right now, because, to the extent that you're able to effectively expand SCHIP and kids' coverage, you take kids out of the equation, and you make it significantly easier, then, for States to address the issue of the uninsured working adults, who are the largest and fastest growing part of the uninsured population. So, a major significant contribution that everyone around the country is looking at, in terms of what we hope Congress can do this year, deals with SCHIP.

Just mention two other things very briefly. One is that we hope that you will resist the temptation to pass laws at the Federal level which will restrict the ability of States to manage our own private insurance markets in ways that work to the advantage of the kinds of experimentations we're doing. There were measures considered by Congress in this last session which, if passed, would have significantly impeded our ability to enact the health reform law that we did, this past April.

The last thing I would just suggest is, as you look at the ways that you can be helpful or not, that you are mindful of the Federal ERISA law, because the Federal ERISA significantly impedes the ability of States to engage employers who do not provide coverage to their workers in this dialogue, this conversation, this process of shared responsibility. It's a significant cloud, a significant impediment, and that, in particular, is one of the significant obstacles States face as we look at trying to spread this important concept of shared responsibility.

Thank you.

Chairman KENNEDY. Thank you very much.

Andy.

STATEMENT OF ANDY STERN, PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION (SEIU)

Mr. STERN. Thank you, Mr. Chairman. And good morning to everyone.

I'm here today on behalf of the 1.9 million members of our union, the largest union of health care workers in this country, and, more

importantly, on behalf of all the hardworking people who showed up at work today.

Health care's been the most talked about, the most worried about, the most studied, and the least acted-on issue, I think, facing our country. As a result, America today doesn't have a health care problem, we have a health care crisis, as your chart showed. And obviously, it's getting worse. And the solution is no longer really a matter of policy, it's a matter of politics. And, as someone said earlier, we not only need an urban solution and a rural solution, or a Democrat and a Republican solution, or a labor and business solution, we need an American solution, and we need it right now.

Many other people here remember the politics of 1994. We tried to fix the health care system. We got pretty close. So, as we begin to seek big solutions again, there's going, inevitably, to be comparisons to 1994, especially by the timid and the naysayers. But the reality, though, this is a very, very different moment in America.

In 1994, there was a ripple of possibilities, led a lot by a new committed President. But today there's actually a tidal wave of demand throughout the entire country.

Second, today polls indicate that 89 percent of all Americans are looking for fundamental, not incremental, change anymore, very different than it was 12 years ago.

Sadly, what's different today than 1994 is that—a result of all of this inaction—we're just a lot worse off for average working Americans. We've all recognized today there are more people uninsured, but we also need to realize what we learned from a recent SEIU and Center for American Progress study, that less than one-quarter—less than one in four—middle-class families can now cope financially with a typical medical emergency. More women went bankrupt last year than graduated college, mostly due to uninsured health care claims. And what's also different is not just the uninsured in trouble, it's the insured, as well, as high copays and deductibles begin to take hold and ripple through the system.

But, finally, and, I think, most profoundly for the committee, this is not our father and grandfather's economy anymore, this is no longer a national economy; it's an international economy. Today, more people went to work in retail than manufacturing in America. Last year, the world produced more transistors than grains of rice, and the transistor actually cost less. Wal-Mart, not GM, is the biggest corporation in the world, and it has a larger GDP—larger sales than the GDP of Venezuela, Singapore, and Ireland. And in 1994, a "blackberry" was nothing more than a piece of fruit.

So, these global economic changes are literally revolutionary, and they have enormous impact on America's competitiveness. By 2008, according to McKinsey & Company, the average Fortune 500 company will spend as much on health care as they make in profit. And that's just crazy. Americans cannot compete, and America cannot compete, in a global economy if we're the only Nation on Earth that puts the price of health care on the cost of the products, when our competitors don't. We are in a race against time, because our health care system is now morphing from comprehensive to catastrophic. Ever-increasing costs are leading more and more business to shed care. And I think it's time we declare that the employer-

based system—health care system is dead in America. It is a relic of the industrial economy. It is a relic of a national economy. And America will not compete in a global economy with an employer-based system.

Now, that's, sort of, the discouraging part of what's different. Here's the encouraging part. The winds of change in America are blowing again, many coming from unlikely directions. I think, and I hope we'll hear from the business community, that people are beginning to appreciate that we need to do something rather dramatic. Last year, I wrote an editorial in the *Wall Street Journal*, sent a letter to all Fortune 500 CEOs about ending the employer-based health care system, and, much to my surprise, I got lots of positive responses.

The insurance industry that we all remember in 1994, through its "Harry and Louise" ad, helped defeat universal health care, now has its own universal health care plan that they put out several months ago, a far different situation than 1994. And around this table are all the States that are finding new ways, common ground, to find solution, whether it's Maine's plan in 2003, whether it's Illinois covering all children and now talking about expansion, or Vermont, and obviously, Massachusetts. And, just Monday, obviously, in the largest State in our Nation, Governor Schwarzenegger produced a universal health care plan, which is a huge step forward in courage, and an opportunity for big change. We saw dozens of congressional candidates run in 2006, leaders like Senator Wyden and Congressman Conyers, and presidential candidates are all now announcing with universal health care plans. I think we'll see another two dozen States, as John said, come out with some substantial increase in health care.

And, finally and most importantly, Americans want something to happen, and they need it to happen now. Virtually none of this was the case in 1994. Then, the forces who were defending the system are now talking about changing the system. And I think we have a unique opportunity.

We need leadership now from the Congress to bring health care to every man, woman, and child in America. It is a moment, a new moment, and I hope we have the courage and the wisdom to seize it.

Thank you.

Chairman KENNEDY. Mr. Burton.

STATEMENT OF LARRY BURTON, EXECUTIVE VICE PRESIDENT, THE BUSINESS ROUNDTABLE, WASHINGTON, DC

Mr. BURTON. Mr. Chairman, Senator Enzi, members of the committee, I'm here representing The Business Roundtable, which is an association of Chief Executive Officers of America's leading corporations. All together, the revenue from the corporations is about $4.5 trillion and covers 10 million employees and 35 million retirees and dependents.

We appreciated working with you last year in a bipartisan way to pass the Health Information Technology legislation that got through the Senate, and we look forward to working with you this year. It's a very important piece of legislation.

Today, however, my message is much broader and stronger. We believe Congress must act urgently on comprehensive reforms so that all Americans can have access to affordable health care. The issues of the uninsured must be tackled. Health care costs must be reduced for all Americans, for our economies, and for our companies.

And for Business Roundtable CEOs, health care costs are the No. 1 cost pressure facing them. It affects job creation, it affects competing in global markets, it affects American household economies, and it forces many Americans, unfortunately, to go without health care coverage at all.

So, the CEOs of The Business Roundtable want to join with traditional and nontraditional partners in what we call a "call to action." We encourage congressional leaders to enact legislation to reduce cost by bringing 21st-century technology to our health care system in legislation that are going to provide Americans with actionable information about cost and quality in the health care services that they need.

Now, your request to us was for some specific recommendations, and I'd like to go there.

First, SCHIP should be reauthorized. It provides low-income children with access to health care coverage.

Second, Congress and State leaders should act on legislation that removes statutory and regulatory barriers to increase health insurance options for Americans who currently don't have coverage.

Third, Senator Coburn, wellness is a very important piece of this equation, and should be emphasized. Whether it's through incentives or public/private programs, every American should understand the importance of diet, exercise, immunizations, and other disease-prevention activities and health promotion programs.

Fourth, we believe consumer-centric health plans are an important option for health care coverage.

Fifth, the Government should release information on the comparative effectiveness of health care treatments, because consumers have a right to know what treatments work and what treatments don't work.

Sixth, every individual in America should have access to information on cost and quality. We've talked about that for the last couple of years. I believe Senator Gregg has a bill in that we support.

Seventh, Congress should permit reimbursement of providers by the Federal Government to be based on quality performance and the use of health information technology by these providers.

Eighth, we believe that all Americans should have access to uniform, secure, interoperable, health care systems, and provide administrative and confidential medical information.

And ninth—and you've heard this before, but I need to say it—we believe that the medical liability laws should be reformed.

So, we believe these are attainable goals. We believe that, getting together with traditional and nontraditional partners, we can move forward to get our health care system working better for all Americans, including those who are uninsured.

Now, many of the efforts that I've talked about are aimed at making the system efficient and providing effective situations so

that we can lower cost and provide better health care. We want to work on these with you. We hope that we can move forward now.

So, I look forward to the discussion today, and thank you for the opportunity to be here.

Chairman KENNEDY. Pat Combs.

STATEMENT OF PAT VREDEVOOGD COMBS, NATIONAL ASSOCIATION OF REALTORS, OWNER, COLDWELL-BANKER-AJS REALTY, GRAND RAPIDS, MICHIGAN

Ms. COMBS. Chairman Kennedy, Ranking Member Enzi, and members of the committee——

Chairman KENNEDY. For the benefit of the members, we had, sort of, hoped that we'd get through, you know, this in 45 minutes or so, so we could get conversation. I know some of our colleagues are going to have to move along. So, if they have a particular kind of question, they're not—we'll certainly entertain it, but that it would be generally hoped—I think we're making good progress, and this has been enormously constructive, but if there are—any of our members feel that they have to excuse themselves because of conflicts, we'll certainly invite their questions to any of those that have spoken or to those other members of the panel.

Thank you.

Ms. COMBS. Thank you.

My name is Pat Vredevoogd Combs. I am vice president of AJS Realty in Grand Rapids, Michigan, but I'm also President of the National Association of Realtors, representing 1.3 million members across this Nation.

I thank you for holding this session, and I appreciate the opportunity to discuss the challenges the small business community faces when looking for affordable health insurance.

I have been a real estate professional for more than 30 years. I know how hard it is to find health insurance when you have no employer-provided coverage. I also know how hard it is to provide affordable health coverage for my employees. My company, which I sold in August, had 35 real estate agents affiliated with the firm, and four salaried employees. With just four employees, finding health coverage was a challenge and very expensive. We did it, but we were the exception. Most realty firms are not able to find affordable health insurance for their employees. A salaried colleague, Lois, recently looked into purchasing her own health care, and the lowest cost plan she found for both she and her husband were $15,000 per year. Sadly, Lois's experience is not uncommon. Many colleagues face the same challenge. Their experience provides a good example of the challenges encountered by small businesses.

You see, real estate agents are not employees of the offices with which they're affiliated. They are independent entities and their own bosses. They are the smallest of small businesses. Real estate firms are also small employers, typically with fewer than five employees. And like other small businesses, they struggle to provide affordable health insurance to their employees. As a result, most real estate agents and employees, like Lois, must find coverage in the individual insurance market, where there is no negotiating and no leverage. You basically take or leave whatever coverage is offered at whatever price is offered. Consequently, today more than

28 percent of the Nation's 1.3 million realtors have no health insurance. If we add family members to that tally, the number of uninsured individuals in households associated with a realtor organization totals 886,000.

Obviously, realtors are not alone in this struggle to obtain affordable health care. More than 46 million Americans find health insurance out of reach; 27 million of these individuals work in small businesses. Without changes, the number of uninsured can only grow, since small firms, and especially self-employed individuals, are predicted to make up an increasing portion of America's workplace.

In 2000, 30 percent of the American workforce was comprised of nontraditional self-employed workers like realtors. By 2010, some predict that figure will be 41 percent.

Let me close by reiterating, the current insurance delivery system does not meet small firms' needs. Bring all of the stakeholders to the table, let us work to find an acceptable solution. The small business community is ready to do all we can to contribute to such an effort.

Again, thank you for inviting me, and I'm happy to take any questions.

[The prepared statement of Ms. Combs follows:]

PREPARED STATEMENT OF PAT VREDEVOOGD COMBS

Chairman Kennedy, Ranking Member Enzi, and members of the committee, thank you for holding this roundtable and giving me the opportunity to talk with you about the challenges that face the Nation's small business community as they search for accessible and affordable health insurance coverage.

My name is Pat Vredevoogd Combs. Until recently, I was the broker/owner of AJS Realty in Grand Rapids, Michigan. My company had 35 independent contractor sales associates affiliated with the firm as well as 4 salaried employees. I also have the honor of serving as the 2007 President of the National Association of REALTORS®.

As a practicing real estate professional for more than 30 years, I know very well how hard it is to find and keep health insurance when you have no employer-provided coverage. I also know how hard it is to find affordable health coverage for your employees when you're the boss.

Having had both responsibilities, I can also tell you that while governors, State insurance commissioners, and insurance industry executives may talk about how well their State regulations or insurance products serve the public's needs, those of us in small businesses who are "on the ground" looking for health insurance don't see the health insurance market in quite the same light. I sometimes wonder if these officials and company executives were forced to shop for their own insurance policy or a small group policy for their staff, would they still feel the same?

My experience is shared not only by my real estate colleagues but by the rapidly growing number of small businesses and self-employed Americans who are part of every sector of our economy.

The real estate sales professionals' search for health coverage is a perfect example of the challenges that the self-employed and small business face today. Real estate agents are not employees of the realty office with which they are affiliated. They are independent contractors, a separate legal business entity—the smallest of small firms. Real estate *firms*, the offices with which these independent agents are affiliated, typically has fewer than five salaried employees—a receptionist, office assistant, or, perhaps, a transaction coordinator.

Today, in most States, real estate agents, other independent contractors and even small firms are forced to look for insurance in the individual insurance market—a market where you basically take or leave whatever coverage is offered. There is no negotiating. There is no leverage. In many cases, a small firm may also find the terms of insurance coverage in the small group market no more favorable than those offered in the individual market.

As the result of this industry structure and the current state of health insurance regulations and industry practices, today 28 percent of the Nation's 1.3 million

REALTORS® do not have *any* health insurance. In a 7-year period, this uninsured percentage doubled—going from a level of 13 percent in 1996 to 28 percent in 2004. That's over 336,000 uninsured working REALTORS®. If we add the number of associated, and likely uninsured, REALTOR® family members to that total, the total number of uninsured individuals affiliated with the REALTOR® organization is 886,000.

In the case of real estate firms, few firms offer health insurance coverage to salaried employees. In 2004, only 13 percent of firms offered coverage to salaried workers. In 1996, the percentage was 34 percent.

It's interesting to note that the percentage of uninsured REALTORS® is almost double that of the Nation as a whole. In 2004, for example, the percent of the U.S. population without health insurance coverage was estimated to be 15.7 percent.[1]

Finding a solution to the problem of the uninsured needs to be a top priority for this Nation. It is a problem that affects over 46 million Americans today. Half of these individuals are the owners and employees of small firms or the self-employed.[2] These same small operations have been widely recognized as the largest creators of new American jobs. We believe that without change, problems with the availability and affordability of small business health coverage will increasingly threaten what has been the main source of job growth in this Nation.

At the same time, as corporations have downsized and the economy has evolved, the share of the U.S. workforce that is self-employed, individual proprietors has grown. The Ford Foundation estimated in 1999 that the number of freelance, independent contractors and temporary workers totaled 37 million individuals.[3] More recently, the General Accounting Office (GAO) estimated that 30 percent of the American workforce in 2000 was comprised of these "non-traditional" workers.[4] By way of comparison, the GAO estimated that manufacturing employment totaled 18 million workers while an additional 20 million worked for some government entity in this same year.

Some have estimated that by 2010, 41 percent of the U.S. workforce will be what David Pink has labeled "free agent" workers.[5] In this new world, a health coverage system of employer-provided health insurance will be even less successful at providing American workers with access to affordable care than it is currently.

It is for this reason that I urge you to include representatives of the small business community in any discussions or efforts to address the solutions to the health care coverage crisis. These discussions must include those familiar with each of the key constituencies that will be impacted by any recommended changes.

I would like to close and let you know that finding a solution to the health insurance access problem is a priority issue for the small business community and the National Association of REALTORS®. As the 2007 president of NAR, I can pledge to you that NAR stands ready to do whatever we can to assist you in your efforts to address this very important and growing problem.

Thank you for giving me the opportunity to share my thoughts. I am happy to take any questions.

Chairman KENNEDY. Thank you very much.

I'll introduce the next three witneses. One is Peter Meade, who's an old friend. He's the Executive Vice President of Blue Cross Blue Shield of Massachusetts, and was essential in getting our health care reform passed in Massachusetts. And through his leadership, Blue Cross has donated $50 million to start experimental health IT programs in Massachusetts.

Peter Harbage is the senior program associate at the New America Foundation. He's a key consultant to Governor Schwarzenegger on the recent plan for health care for all Californians.

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[1] Carmen DeNavas-Walt, Bernadette D. Proctor, and Cheryl Hill Lee, U.S. Census Bureau, Current Population Reports, P60-229, *Income, Poverty, and Health Insurance Coverage in the United States: 2004*, U.S. Government Printing Office, Washington, DC, 2005.

[2] Employees Benefit Research Institute, "The Working Uninsured: Who They Are, How They Have Changed, and The Consequences of Being Uninsured," EBRI Issue Brief No. 224 (August 31, 2000).

[3] Elena Cabrel, "Building Safety Nets for the New Workforce," Ford Foundation Report (Spring/Summer 1999).

[4] General Accounting Office, "Contingent Workers: Incomes and Benefits Tend to Lag Behind Those in the Rest of the Workforce," report no. HEHS-00-76 (June 30, 2000).

[5] David H. Pink, *Free Agent Nation*, (New York: Warner Books, 2001).

Joseph Antos, the Wilson Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, is a nationally recognized economist and will speak of market initiatives to improve health care.

Peter.

STATEMENT OF PETER MEADE, EXECUTIVE VICE PRESIDENT, BLUE CROSS BLUE SHIELD OF MASSACHUSETTS, BOSTON, MASSACHUSETTS

Mr. MEADE. Chairman Kennedy, Senator Enzi, members of the committee, in 1932 Justice Louis Brandeis wrote,

> "There must be power in States and the Nation to remold through experimentation. Our practices and institutions must be able to meet changing social and economic needs. It's one of the happy incidents of the Federal system that a single courageous State may, if its citizens choose, serve as a laboratory and try novel social and economic experiments without risk to the rest of the country."

I'm not sitting here before you today to say Massachusetts found "the answer" to health care. We believe we did not discover the Rosetta Stone. We believe we have found an answer that may, in fact, work for us. To understand why Massachusetts seized this opportunity, it's important to note some things. We had fewer uninsured than any other State. The employer coverage in Massachusetts was already high, over 65 percent, as compared to the rest of the Nation, at 56 percent. Even our dental, there's a penetration of 71 percent of dental in Massachusetts, versus 50 percent in the Nation. We were spending more, or, if I could be more precise, misspending a billion dollars in our uncompensated care pool that, if managed correctly, we thought we could do more. We operate in what some may consider a highly regulated market with requirements such as guaranteed issue and community rating. There is also the looming threat of losing over 385 million Federal dollars if our Medicaid waiver was not renewed. These factors, along with a strong community and political input, leaders who are willing to work across the aisle, really did make a difference.

And I would be remiss if I didn't mention the role that was played by the Chair of this committee. The law simply would not have been enacted in Massachusetts if it was not for the leadership of Senator Kennedy.

The law expands Medicaid eligibility. It offers subsidies to help low-income people, those earning up to three times the Federal poverty level. They will have assistance in purchasing health assurance. The law put forth reform for the nongroup and small-group market. Our actuaries estimate that the individual market price will go down next year by 20 percent, the small-group market will go up by 1½ to 3 percent, a significant savings for the majority of people in that combined market. There is a Healthcare Disparities Council that will piggyback on the work done by the city of Boston on health care disparities in our communities.

We believe that this law does make a difference, and can make a difference, in Massachusetts. The law requires employers with 11 or more full-time employees to offer health care coverage. If they do not, they are subject to a $295-per-employee-per-year assessment and may be billed for services their uninsured employees receive. As John McDonough indicated, to date, tens of thousands have already signed up for commonwealth care, and groups esti-

mated that, by the end of February, there will be 100,000 people receiving health insurance in Massachusetts who did not receive it last year.

Now, while there's no single answer to solving the Nation's uninsured crisis, there are several things the Federal Government can do to help families afford quality health care and reduce health care costs.

First, use the Federal Government's influence as one of the Nation's largest payers and providers of health insurance to improve the quality of care that patients receive. By doing so, we can save lives, as well as money. As a company, Blue Cross of Massachusetts already spends several hundred million dollars providing incentives, rewarding all those wonderful physicians and hospitals that are working so hard to improve the quality of care. We expect what we call our "quality investment" will significantly increase and help reduce the misuse, overuse, and underuse of health care. And we hope that the Federal Government will continue in its efforts in this direction.

We believe that health information technology is also an essential component of closing the gap between quality of care that patients do receive and what they should receive. We, as a company, Blue Cross Blue Shield of Massachusetts, have committed $50 million for experimentation in Massachusetts to move the ball forward. Three communities in Massachusetts are already beginning processes of using eHealth as a way to improve health care. We believe it will be more efficient and it will improve the quality of health care we deliver.

We also believe that fully funding SCHIP, while protecting and exploring successful expansion of Medicaid, is important. Medicaid and SCHIP have been enormously successful in providing high-quality accessible health care for the most vulnerable amongst our Nation's vulnerable people, all of our children. We also think you should consider the help you can give to States as they implement their own health care reform.

Finally, do no harm. In our estimation, this means not advancing legislation that would undermine the efforts of States, like Massachusetts, California, Vermont, that are trying to decrease costs, increase quality, and improve access to health care.

Thank you very much.

[The prepared statement of Mr. Meade follows:]

PREPARED STATEMENT OF PETER MEADE

Mr. Chairman, Senator Enzi and members of the committee, I am pleased to be here today on behalf of Blue Cross Blue Shield of Massachusetts to discuss the challenges and opportunities to expand coverage to quality health care for all Americans. I am Peter Meade, Executive Vice President at Blue Cross Blue Shield of Massachusetts.

You have asked two very important questions:

1. What are major challenges facing health care today and best options for expanding coverage to all Americans?

2. How can Congress help families afford **quality health care** and reduce health care costs without diminishing the **quality of care** provided to patients?

I hope that I can give you some insights as to how Massachusetts approached the first question and also some thoughts on what Congress can do to deal with the very important issue posed by the second.

BACKGROUND

In a 1932 opinion, U.S. Supreme Court Justice Louis Brandeis wrote,

> "There must be power in the States and the Nation to remold, through experimentation, our practices and institutions to meet changing social and economic needs. It is one of the happy incidents of the Federal system that a single courageous State may, if its citizens choose, serve as a laboratory and try novel social and economic experiments without risk to the rest of the country."

I am not standing before you today to say that Massachusetts came up with THE answer to solving the uninsured crisis; instead we came up with AN answer that we hope will succeed for Massachusetts.

Blue Cross Blue Shield of Massachusetts is a not-for-profit organization that was founded 70 years ago by a group of community-minded business leaders. Our history and our future is one of collaboration with the community to improve the health and quality of care that our members, and citizens of the Commonwealth, receive. As a not-for-profit, we believe that our dividends are to the community. Eighty-eight percent of the premiums we receive are returned through member benefits. Our administrative costs of just over 10 percent essentially allow us to break even in terms of operating margin, which we have been able to do in recent years.

In addition to our corporate philanthropy, we have directed our "community dividends" to important initiatives that expand access to quality health care. The most notable among these is our Foundation. In 2001, we established the Blue Cross Blue Shield of Massachusetts Foundation as a contemporary expression of our historic commitment to those in need. The Foundation's mission is to expand access to health care. We provided an initial endowment of $55 million and have continued to contribute to the Foundation, growing its endowment to more than $90 million today. By the end of this year, the Foundation's endowment is expected to top $100 million.

Likewise, our $50 million commitment to the Massachusetts eHealth Collaborative (MAeHC), an initiative to establish a statewide electronic health records system to enhance the quality, efficiency and safety of care in Massachusetts, will make patient information, for those communities selected to pilot the program, available to a physician at the click of a mouse. Our $3 million commitment to Massachusetts Hospitals and the Institute for Healthcare Improvement (IHI), for programs focusing on issues such as clinical outcomes, patient safety, patient satisfaction, office and hospital redesign, health disparities and, of course, health care access, will also serve to close the quality chasm and improve the health of our members.

For every man, woman and child and the economy that we support, it is vital that we do health care right in Massachusetts. We are an undisputed leader in medical care and research with world-class hospitals, medical schools, research laboratories and life sciences companies. We are fortunate to have first-rate community hospitals and health centers all across the State and also share our marketplace with world-class insurers—including Harvard Pilgrim HealthCare, Tufts Health Plan to Fallon Community Health Plan. We are all among the top 10 health plans in the Nation according to U.S. News and World Report and the National Committee for Quality Assurance.

When you consider what was at stake for Massachusetts, you can appreciate why instituting comprehensive health reform was a priority and why through the strong leadership of our President and CEO, Cleve Killingsworth, that Blue Cross Blue Shield of Massachusetts was pleased to be part of the process.

MASSACHUSETTS HEALTH CARE REFORM

To understand why Massachusetts seized this historic opportunity, it is important to understand the existing climate in the Commonwealth that allowed health reform to take place. First, we have a relatively low number of uninsured—as compared with other States. Employer coverage in the State is already high (over 65 percent) as compared to the rest of the Nation (56 percent). Even dental insurance has penetrated the market to a greater degree in Massachusetts (71 percent) versus the Nation (50 percent). We were spending (or more correctly, misspending) over $1 billion annually on services for the uninsured and underinsured. We already operate in what some may consider a highly regulated market with requirements such as guaranteed issue and community rating. There was also the looming threat of losing over $385 million Federal dollars if our Medicaid waiver was not renewed. These factors, along with a strong community and political will of leaders across the State created the dynamic that allowed health reform to become a reality.

I would be remiss if I did not acknowledge the efforts of Senator Kennedy, whose leadership was absolutely critical to the ultimate passage of the legislation.

WHAT DID MASSACHUSETTS DO?

Despite the State's best efforts to reduce the number of uninsured, Massachusetts still faced over 550,000 people without health insurance. As of July 1, 2007, all residents of Massachusetts will be required to have health insurance. There are several significant parts of the law:

- the law expands Medicaid eligibility;
- the law offers a subsidy program to help low-income people (up to 300 percent Federal Poverty Level) purchase health insurance;
- the law puts forth reforms for the non-group and small group markets;
- the law creates an individual mandate enforced by financial penalties; and
- the law requires employers with 11 or more full-time employees to offer health coverage or be subject to a $295/per employee assessment as well as face being billed for services their uninsured employees receive.

To date, tens of thousands have already signed up for Commonwealth Care (50,000 have been determined to be eligible—29,000 have signed up).

WHAT CAN BE DONE AT THE FEDERAL LEVEL?

While there is no single answer to solving the Nation's uninsured crisis, there are several things that the Federal Government can do to help families afford quality health care and reduce health care costs without diminishing the quality of care provided to patients.

First, use the Federal Government's influence as one of the Nation's largest payors and providers of health care to improve the quality of care that patients receive. By doing so, we can save lives and money.

Researchers at the Rand Corporation tell us that patients fail to receive recommended care half of the time. More than 1 in 10 are receiving care that is not recommended or downright harmful.

The human cost of these failures is reason enough to act. But their monetary cost is substantial as well. Experts say as many as 30 cents out of every dollar spent on health care in the United States may be wasted.

The Institute of Medicine calls it the "quality chasm"—the gap between the knowledge we possess and the care we actually deliver. In Massachusetts we call it the excellence imperative—the gap between our performance and our potential—our pride at doing well and our enduring aspiration to "do better." As a Company, we already spend several hundred million dollars incenting those individual physicians and institutions that are trying to "do better." While we plan that our "quality investment" in those who are moving forward to reduce the misuse, overuse and underuse of health care will significantly increase, we also hope that the Federal Government will make strides in this direction as well. Health information technology is also an essential component to closing the gap between the quality of care that patients do receive and what they should receive.

Each of us who is privileged to work with health care providers knows that there is no profession more devoted. They already do all they can with the tools they possess. For them to do better, the system itself must change. Health care professionals work hard. Sweeping, systemic change can empower them to work smarter.

The Federal Government can seek creative ways to: integrate safety and reliability into the basic structure of the health care system; harness technology to eliminate errors; empower doctors to spend more time with patients and patients to make more informed decisions. Together, we can do more to help the people of this great Nation live longer and healthier lives.

This goal of delivering high quality, safe and effective health care must engage the entirety of stakeholders—from living rooms to hospital rooms, nurses, physicians and pharmacists alike, policymakers as well as providers, consumers and, of course, insurers too. Because medical care is only as good as the system that delivers it, we applaud your early efforts in this area, but urge you to do more.

Second, fully fund SCHIP, while protecting and exploring successful expansions of Medicaid. Medicaid and SCHIP have been enormously successful in providing high quality, accessible health care for the most vulnerable among us, our Nation's children. With fewer employers offering coverage nationally, SCHIP and Medicaid remain critical to ensuring children are able to maintain access to vital health care coverage. While Massachusetts and New England have a long tradition of covering our children, we are vulnerable to any action or inaction by the Federal Government to live up to its shared responsibility. Reauthorization of SCHIP and Medicaid appropriations will be before this committee and the full Congress this year. The mes-

sage on SCHIP and Medicaid is simple. Pay now or pay much more later. The stakes are high, our children's physical and mental health is at stake (New England Alliance for Children's Health).

Third, consider the help you can give to States as they implement their own health reform efforts. Whether in the form of providing for reinsurance in recognition of the fact that the top 20 percent of patients use more than 80 percent of the resources, or funding for programs that help States subsidize health insurance, the Federal Government can certainly play an important role in solving the Nation's uninsured crisis.

Fourth, do no harm. In our estimation, this means not advancing legislation that would undermine the efforts of States, like Massachusetts, that are trying to decrease costs, increase quality and improve access to health care. While well-intentioned, Association Health Plans (AHPs) or legislation that fundamentally disrupts or destabilizes the health insurance market is not the answer.

On behalf of my colleagues at Blue Cross Blue Shield of Massachusetts, we look forward to working with the HELP Committee as it addresses the important issues of improving access to quality health care. Thank you again for the opportunity to testify. I look forward to any questions you may have.

Chairman KENNEDY. Thank you, Peter.

Peter Harbage.

STATEMENT OF PETER HARBAGE, NEW AMERICA FOUNDATION, WASHINGTON, DC

Mr. HARBAGE. Mr. Chairman, Senator Enzi, thank you for having me here today. It's a privilege.

My name is Peter Harbage. I'm with the New America Foundation. It's a nonpartisan think-tank here in town that prides itself on being neither right nor left.

We've heard, today, about the broken health care system and the resulting toll. To fix this health care system, New America has long supported the concept of shared responsibility based on an individual mandate, the idea that all stakeholders in the health care system have a responsibility to help make insurance accessible and affordable, and then individuals have a responsibility to obtain insurance.

With my time, I'd like to share how this concept has been playing out, in California, where New America has been lucky enough to be one of several entities advising the Schwarzenegger administration.

Just 2 days ago, the Governor announced his fully financed health reform plan. There's no other way to say it, the plan is audacious. It presents a vision for how to reform the health care system in California and create an efficient market. It also marks a sincere effort to address the political needs of both political parties.

Broadly, the plan offers comprehensive ideas on wellness, prevention, and affordability. It has many, many moving parts. What I'd like to do is just run through some of the highlights of the Governor's coverage plan.

In trying to help cover California's 6 million or so uninsured, the vast majority of whom are employed, Governor Schwarzenegger has fully embraced shared responsibility, due, in no small part, to Massachusetts' trailblazing. Interestingly, though, is—Peter Meade went through why health reform is a little bit easier in Massachusetts, because of higher player participation, lower uninsured rate—by virtually any such measure, California would be toward the bottom of the scale, and certainly faces an uphill battle.

At the center of the Governor's plan is the individual, who must purchase insurance. At the same time, government have a responsibility to help make insurance affordable. The plan calls for a major expansion of public programs, the creation of a statewide purchasing pool, with subsidies available to those up to 250 percent of poverty, and it calls for new tax breaks to encourage health savings accounts.

But all other stakeholders have to do their part, as well. Employers not offering insurance, with 10 or more employees, will have to pay a fee of 4 percent of payroll. Health plans have new rules to follow, including guarantee issue, modified community rating. And the Governor has also called for an 85-percent loss ratio. What this means is that, for health plans, for every $100 they bring in, in premiums, $85 will actually have to go toward the purchase of health benefits, leaving $15 out of that 100 to go toward overhead and profits. New wellness activities will be required of all health plans, as well.

Doctors have new fees of 2 percent of revenue, and hospitals have new fees of 4 percent of revenue.

These are the responsibilities—this is the hard part—the responsibilities that have to be met in order to get to the benefits. The top benefit that the Governor has articulated is, he wants to see a healthier California. Universal coverage means that Californians will be able to get the care that they deserve. It also helps eliminate the hidden tax of cost-shifting, where those with insurance are already paying to cover those and help those who do not have insurance. Under the Governor's plans, he estimates that providers, doctors and hospitals, will see greater revenues, even with the new fees.

Now, will all Californians agree to this plan? No. It will be an uphill battle. But the Governor has stated his willingness, as have all the legislative leaders stated their willingness, to work together to achieve change.

But, as with Massachusetts last year, California is certain to spark debate among States. And yet, if we are ever to achieve universal coverage here in the United States, States cannot be left on their own. Leadership from the White House and Congress is necessary, as well. Indeed, even California, under its plan, is calling for Federal help. The Schwarzenegger plan would enroll almost 1 million new people into Medicaid in the State and Children—at the State Children's Health Insurance Program, SCHIP. This is done under existing Federal authority, and would not require any new waivers. But about half of the plan's projected spending would come from Federal dollars. Just under half.

In that vein, I'd just like to close by adding my voice to what we have already on the reauthorization of SCHIP. The reauthorization of SCHIP, and that—in fact, its expansion, will be critical to helping States achieve coverage and to supporting Governor Schwarzenegger in his effort.

Also, from the perspective of the New America Foundation, I just want to close by saying that it'll be important to fully understand the impact of the DRA citizenship requirements and what those will mean to States, and the impact that those requirements will have on making it more difficult for Americans to get the health

insurance that they need. Hopefully, that's something the committee can consider this year.

Thank you for your time.

Chairman KENNEDY. Thank you very much.

Mr. Antos.

STATEMENT OF JOSEPH ANTOS, WILSON H. TAYLOR SCHOLAR IN HEALTH CARE AND RETIREMENT POLICY AT THE AMERICAN ENTERPRISE INSTITUTE, WASHINGTON, DC

Mr. ANTOS. Thank you, Mr. Chairman and Senator Enzi and members of the committee. I'm Joe Antos, of the American Enterprise Institute.

We have a real opportunity this year to improve the functioning of the health insurance market and help make health coverage more affordable for millions of Americans. We need to build on the initiatives that the Federal Government has already taken. We need to build on the initiatives that the States are taking, and the initiatives the States will be taking. We need to build on the initiatives that the private sector is taking, as well. Let's not forget them.

As Senator Kennedy rightly pointed out, cost is a big issue here. It's a big, big problem. Cost is probably the major reason why there are so many uninsured Americans. Certainly, high cost is a major reason why employers are having trouble offering health coverage, especially small employers. So, we need to do something about cost.

The positive side of that is that everybody recognizes that cost is the problem, and so, that's motivating a lot of activity in the private sector and the public sector to try to get a handle on this, in small ways and large ways. And that's a good thing. We need to build on those initiatives.

I would point to a couple of things. At the Federal level, I think that the two most important Federal activities in the last few years was the establishment of the health savings account concept, which is a milestone, depending on how you look at it. It is a milestone in the evolution of the insurance market. Its intention is certainly to promote greater awareness of cost on the part of everybody, not just patients, but also practitioners. That's very important. They need to know that what they do costs real money.

Perhaps the most important part of the HSA legislation was to bring right to the forefront the idea that people actually need information if they're going to make good decisions. And a lot has happened in the last 3 years, and a lot will happen in the next few years, to make that a reality.

The other major Federal initiative is to give greater flexibility to the States, and States are taking it. Massachusetts is a great example. California is on the verge of possibly doing something big, as well.

I'm going to just make a few quick comments on Massachusetts.

It's an innovative plan. As Peter and others said, it's complicated. It's a mandate on individuals for coverage. There's a subsidy to help low-income people afford that coverage. And there is the remarkable connector that will, in ways that we don't know yet, facilitate insurance purchasing by a lot of people. That's the good news.

I think the plan has certain important principles that all States should consider and the Federal should consider, and, in particular, this idea of shifting away from large uninsured patients pools to money targeted to individuals to buy health insurance, I think, is a very good idea. "Money follows the individual," is a very important principle. And choice of health insurance should also follow the individual. The individual should be able to make up his or her own mind about what to do. Understand that the mandate is an important tool, as well.

Critical to all this is the ability of this system to deliver affordable health insurance. I think there are some real challenges there. Massachusetts is one of the most heavily mandated—benefit-mandated States in the country. The Massachusetts health care market is highly concentrated. And so, an important assumption that was made in passing this legislation was that many of these things could be overcome over time; and, in particular, the idea that there could be more efficient health care delivery in the State. That's a very good goal in Massachusetts, and we all should work on that. But I think the kinds of savings that were predicted early are going to be hard to reach.

Another big problem which we're seeing already, the average person is not necessarily going to buy the insurance, no matter how well it's subsidized. There was a story last week in the Boston Globe that said that, in the early rollout, with multipremiums ranging from $18 to $58 a month, it's hard to sell the product. So, that's going to be a really major challenge.

And then, finally, the fiscal pressures that are going to be in—that are developing in Massachusetts that will be caused by this reform, which doesn't quite, you know, meet all of the critical objectives that one might have, and there are a lot of uncertainties—there are going to be fiscal pressures building up, and those fiscal pressures are going to cause the State to look again at, Where can they get the money, and what can they do about reducing health care costs?

I agree with all the speakers who said that Congress has a golden opportunity to make some real progress here. We need to build on Medicaid/State flexibility. We need to, of course, reauthorize SCHIP. We need to make sure that there's flexibility in that reauthorization. The health information technology bill is an important bill. We'll need to get that out. We need to do something about making coverage affordable for small businesses.

I think that Congress should send a signal to States that if several States want to join together in a compact to reduce some of the cross-border problems with selling insurance, Congress should show at least a yellow light, if not a green light.

It's a tight budget climate this year. It'll be tough to make major expansions in Federal programs, but there are opportunities.

Thank you.

[The prepared statement of Mr. Antos follows:]

PREPARED STATEMENT OF JOSEPH R. ANTOS, PH.D.

Mr. Chairman and members of the committee, it is a pleasure to appear before you today. I am Joseph Antos, the Wilson H. Taylor Scholar in Health Care and Retirement Policy at the American Enterprise Institute, a Washington-based think tank. My testimony will address the opportunities we have to improve the func-

tioning of the health insurance market and make health coverage more affordable for millions of Americans.

The States, most notably Massachusetts, have launched bold experiments that could improve access to private insurance and promote more efficient health care delivery. The Federal Government has opened the door to new types of health insurance, including high-deductible plans coupled with Health Savings Accounts (HSAs). Congress has an opportunity this year to build on these initiatives and make additional progress on the problems of the uninsured.

INSURANCE COSTS REMAIN HIGH DESPITE RECENT SLOWDOWN

A recently-released study from the Centers for Medicare and Medicaid Services (CMS) reports that runaway increases in the cost of health care appear to have eased, at least temporarily. According to the study, U.S. health spending in 2005 increased 6.9 percent to almost $2.0 trillion.[1] This is the third year in a row when national health spending grew at a slower rate than the previous year. National health spending grew 7.2 percent in 2004.

Although this is good news, it is tempered by the fact that health costs continue to grow more rapidly than the economy. Over the past 35 years, health spending has grown at an average annual rate of 9.8 percent while GDP has grown at about 7.4 percent, both measured in nominal terms. In 2005, the disparity in growth rates narrowed, but health spending still outpaced the economy. A sharp slowdown in prescription drug spending is the main factor driving the recent trend. Notably, there has been no comparable slowdown in spending for hospital care, which has grown at nearly an 8.0 percent growth rate for the last few years.

Private health insurance premiums have also risen more slowly, but those premiums remain expensive. According to CMS, premiums grew 6.6 percent in 2005, down from the 7.9 percent increase in 2004. A recent survey of employer health benefits shows that the cost of family coverage in employer-sponsored plans averaged $11,480 in 2006, up 7.7 percent from 2005.[2] Small firms have faced more rapid cost escalation than larger firms; the average premium for firms with fewer than 200 workers grew 8.8 percent in 2006 compared with 7.0 percent for larger firms.

Nearly all large firms offer health benefits, but only about 60 percent of small firms (with fewer than 200 employees) offered coverage in 2006.[3] Only two-thirds of workers in firms offering a health plan are covered by that plan. Some of the workers who are not enrolled may have coverage from some other source (such as a spouse), but some are not eligible for coverage and others reject coverage even though they are eligible.

High cost is a major reason why an employer, and particularly a small employer, might not offer health coverage to its workers. People who do not have access to a health plan from an employer must purchase coverage on the individual market, which typically means higher premiums, more narrow benefits, or both. Moreover, those who buy health insurance on the individual market generally cannot take advantage of a major tax break: premiums paid for employer-sponsored health insurance are excluded from taxable income.[4] Without the benefits of group purchasing or the tax preference, many people go without insurance rather than pay unaffordable premiums.

RECENT INITIATIVES ARE PROMISING

The high cost of health care is driving efforts in both the private and public sectors to improve the performance of the health system. Employers have taken steps to promote high-value health care and information that can inform the purchase and use of health care. The Leapfrog Group is a well-known example of such private sector activity. Numerous initiatives also are underway in Federal and State health programs to improve health care delivery and make limited funds go further. Employers, insurers, and government programs are all involved in testing and developing pay for performance, disease management, improved consumer information, and a host of other new ideas.

The most important recent Federal initiatives to promote more efficient and effective use of our health dollars are the enactment of HSAs and the expanded flexi-

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[1] Aaron Catlin and others, "National Health Spending in 2005: The Slowdown Continues," *Health Affairs*, January/February 2007: 142–153.

[2] Kaiser Family Foundation (KFF) and Health Research and Educational Trust (HRET), *Employer Health Benefits: 2006 Annual Survey*, *http://www.kff.org/insurance/7527/index.cfm.*

[3] KFF and HRET, 2006.

[4] The self-employed receive a partial tax break. They may exclude their premium payments from income subject to the personal income tax, but not from the payroll tax. Others who purchase coverage on the non-group market do not receive any tax benefits.

bility given to States to reform their Medicaid programs. The HSA provision in the Medicare Modernization Act of 2003 is a milestone in the evolution of the insurance market. Consumer-directed health plans, which combine high-deductible insurance with health savings accounts, promote greater awareness of the cost of care on the part of both consumers and providers. The HSA provision extends a tax break for contributions to the accounts that partly levels the field between insured health expenses and expenses that are paid out of pocket.

According to a recent survey, 3.2 million people are covered by HSA-compatible health plans as of January 2006.[5] Although that represents a small percentage of the entire insurance market, employers and insurers appear interested in exploring the potential of such insurance products to lower costs. Importantly, the introduction of HSA-compatible insurance has focused attention on the fact that consumers cannot become smarter purchasers without information about their treatment alternatives, the quality of care offered by different providers, and the price of care. Such data are needed by all patients, not only those with consumer-directed health plans.

State Medicaid programs also have been given greater flexibility to innovate through the expanded use of Federal waivers. CMS introduced the Health Insurance Flexibility and Accountability (HIFA) initiative in 2001. HIFA allows States to restructure their Medicaid and State Children's Health Insurance Programs, including modifying enrollment, changing benefits, increasing beneficiary cost sharing, and providing financial assistance for the purchase of private health insurance.[6] The 2005 Deficit Reduction Act gave States even more flexibility to redesign their Medicaid programs, including the ability to customize benefits for different groups of beneficiaries.

A number of States are introducing a stronger consumer focus to their Medicaid programs through waivers and State plan amendments.[7] For example, Florida is moving to a system of risk-adjusted subsidies for individuals that can be used to enroll in a Medicaid managed care plan or buy into an employer plan or purchase individual coverage. Beneficiaries would also have healthy care accounts through which they could earn additional contributions by adopting a healthy lifestyle. Vermont has also adopted capitated payments for its Medicaid program. Other States, including West Virginia and Kentucky, have created benefit tiers, with more coverage for people with greater health needs.

INNOVATIVE MASSACHUSETTS PLAN FACES CHALLENGES

The Massachusetts health reform signed into law by Governor Mitt Romney in April 2006 has attracted national attention.[8] The plan's goal is health insurance for virtually all Massachusetts citizens, to be achieved by a mandate on individuals to buy coverage and a subsidy for low-income persons who otherwise could not afford it. The plan also creates an insurance "Connector" which facilitates insurance pooling and purchasing by individuals outside the workplace.

Agreement on the Massachusetts plan was reached because of a unique set of circumstances. The State was faced with the loss of $385 million in Federal funds for its uncompensated care pool unless a new approach was developed to reduce the number of people without insurance.[9] The State's economy was in good shape, and the percentage of people without coverage was low in comparison to other States—10.7 percent compared with 15.7 percent nationwide over the period 2003 to 2005.[10] The State has a history of supporting insurance mandates, and consensus emerged across political lines.

There are a variety of attractive features of Massachusetts' plan. Instead of paying hospitals for their uncompensated care, those funds will be used to provide individual subsidies for the purchase of insurance. Families with incomes up to the pov-

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[5] America's Health Insurance Plans (AHIP), *January 2006 Census Shows 3.2 Million People Covered By HSA Plans, http://www.ahipresearch.org/pdfs/HSAHDHPReportJanuary2006.pdf.*

[6] Teresa A. Coughlin and others, "An Early Look at Ten State HIFA Medicaid Waivers," *Health Affairs* web exclusive, April 25, 2006: W204–W216, *http://content.healthaffairs.org/cgi/content/full/25/3/w204.*

[7] Cindy Mann and Samantha Artiga, *New Developments in Medicaid Coverage: Who Bears Financial Risk and Responsibility*?, Kaiser Commission on Medicaid and the Uninsured, Issue Paper #7507, June 2006, *http://www.kff.org/medicaid/upload/7507.pdf.*

[8] John E. McDonough and others, "The Third Wave of Massachusetts Health Care Access Reform," *Health Affairs* web exclusive, September 14, 2006: W420-W431, *http://content.healthaffairs.org/cgi/reprint/25/6/w420.*

[9] Edmund F. Haislmaier and Nina Owcharenko, "The Massachusetts Approach: A New Way to Restructure State Health Insurance Markets and Public Programs," *Health Affairs* November/December 2006: 1580–1590.

[10] Carmen DeNavas-Walt and others, *Income, Poverty, and Health Insurance Coverage in the United States: 2005*, U.S. Census Bureau, Current Population Report P60–231, August 2006.

erty level will receive full subsidies, paying no premiums and responsible for modest copayments. Higher-income families up to 300 percent of poverty will receive a sliding-scale subsidy. This "money follows the individual" principle is an important element in assuring accountability in the health system.

The Connector could simplify the purchase of health insurance for individuals, providing a choice of health plans and offering tax benefits for workers who do not have access to an employer-sponsored health plan. Employers must offer insurance to their workers, but small employers who do not offer coverage themselves can designate the Connector as the source of insurance. Those employers must establish section 125 cafeteria plans, allowing workers to pay premiums with pretax dollars but otherwise not requiring an employer premium contribution.

The Massachusetts reform plan is complex and faces many challenges as it unfolds over the next few years. A critical factor in the success of the plan is the ability to deliver affordable health insurance coverage, as determined by the Connector. The high cost of health insurance in the State, exacerbated by State mandates and market conditions, makes achieving that goal a difficult challenge.

Massachusetts has some of the most costly mandated benefits in the Nation, including coverage for infertility treatments and generous mental health coverage.[11] The health reform law did not remove those mandates. The one exception is new insurance products designed exclusively for 19- to 26-year olds with no employer-sponsored coverage. Considering the difficulty of marketing to this small group of low-income young people who typically have little interest in health insurance, the narrow exemption on mandates is not likely to do much to increase the purchase of insurance or make it affordable.

In addition, concentration in the Massachusetts health market keeps health care costs high.[12] The reform plan assumes that those costs will be squeezed down by the use of "value-driven" networks of providers and other changes, including additional cost-sharing by beneficiaries. "Any willing provider" restrictions on health plans are dropped, which could lead some insurers to direct their patients to less expensive providers. However, the State may have been optimistic in the savings possible through such mechanisms. According to early estimates, the State expects monthly premiums in the small group market to drop by as much as 55 percent, from $350 to $154.[13] While not impossible, such an improvement seems highly unlikely.

Even if premiums could fall by such a large amount, it is not clear that the average person in Massachusetts would regard health insurance as affordable. There are some early signs that interest in obtaining health insurance may not be high, particularly among low-income workers. Many of them have relied on walk-in clinics and free emergency room care, and they may not want to pay for care they previously received at no cost.[14] Even with subsidized monthly premiums ranging from $18 to $58, the new coverage might look like a bad buy to people in the lowest income range.

The mandates on individuals and employers are unlikely to push up enrollment in the face of high insurance premiums. The initial penalty for individuals who do not have coverage is the loss of the personal exemption under Massachusetts income tax, worth roughly $200 to $400.[15] The initial penalty for firms that do not offer health insurance is an annual assessment of up to $295 per worker. Neither penalty is likely to have much impact on insurance take-up. Although steeper penalties are part of the Massachusetts plan, it remains to be seen whether the legislature will allow them to stand if there is much public opposition.

The Massachusetts plan is a bold initiative that intends to improve the functioning of the private insurance market rather than replacing it with government programs. The Connector gives residents one-stop shopping for insurance and promotes more effective competition among insurers and health plans, but it is only a first step. The recent legislation can be criticized for failing to more aggressively address the cost of health care in the State. Fiscal pressures in the coming years are

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[11] Jon Camire and Dianna Welch, "Turning Debate Into Action: Universal Health Care in Massachusetts," *Contingencies*, September/October 2006: 32–39.

[12] Tom Miller, "Massachusetts: More Mirage Than Miracle," *Health Affairs* web exclusive, September 14, 2006: W450–W452, *http://content.healthaffairs.org/cgi/reprint/25/6/w450.*

[13] "Massachusetts Health Care Reform," slide presentation by Timothy R. Murphy, Massachusetts Secretary of Health and Human Services, May 15, 2006.

[14] Jeffrey Krasner, "Sign-Up Push is on the Health Coverage," *Boston Globe*, December 29, 2006.

[15] For 2006, the personal exemption is $3,850 for an individual return and $7,700 for a couple filing jointly. The income tax rate is 5.3%. See *http://www.mass.gov/?pageID=dorhomepage&L=1&L0=Home&sid=Ador.*

likely to cause Massachusetts to take another hard look at its health reform and seek new ways to promote high-value, effective, and appropriate health care.

NEW INITIATIVES SHOULD BE ADVANCED

Although there are many reasons why someone might not have health insurance, the high cost of coverage is the paramount factor. As the latest national health spending data discussed earlier demonstrate, the rising cost of health care is a systemwide problem and there are no simple solutions. We need better information on what really works in health care, delivery systems that operate efficiently, and improved decisionmaking by patients, providers, and health plans.

Some policymakers advocate expanding Medicare eligibility as a way of increasing access to insurance, but such a proposal would do nothing to address the more fundamental issue of cost growth. Indeed, Medicare spending has rarely deviated from the cost trends seen in the rest of the health sector, once differences in benefits are taken into account.[16] That is hardly surprising: Medicare and private insurance operate in the same health system and are affected similarly by advances in health care, changes in consumer expectations, and other forces affecting spending growth.

No one has the complete answer to the health care cost problem, but Federal, State, and private entities are busy developing policy options that could help ameliorate the spending crisis.[17] Congress should promote further efforts by the States to shape their health programs to meet the needs of their populations. The Massachusetts reform is not for every State, but every State has the potential to develop its own approach to improving the effectiveness of its Medicaid program.

The reauthorization of the State Children's Health Insurance Program (SCHIP) can be an opportunity to enhance the flexibility States have to make their SCHIP dollars go further. The health information technology bill, which stalled in Congress last year, can promote the adoption of a nationwide interoperable information system that could help improve the quality of care and avoid unnecessary spending. The challenges faced by small businesses in offering health benefits to their workers should be addressed. Promising ideas include small business health plans and widening access to insurance by reducing disparities in State insurance regulation. Congress could encourage States to form regional compacts that would reduce regulatory barriers and promote competition in the insurance market.

Policymakers have an opportunity this year to help the uninsured. In a tight budget climate, that does not mean a massive expansion of Federal programs. Congress should look to prudent legislation to reduce unnecessary spending, promote efficiency, and build on the innovative ideas for real reform found at all levels in the health system.

Chairman KENNEDY. Thank you very much.

Now our final witnesses. John Goodman is President and CEO of the National Center for Policy Analysis. He's an economist, who will speak on consumer-directed health care.

Karen Davis, President of the Commonwealth Fund, is a nationally recognized economist, with a distinguished career in public policy and research.

And my old friend, Debra Ness, is President of the National Partnership for Women and Families. She led the initiative to reduce health costs through better use of health IT, care coordination, and rewarding high quality.

John.

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[16] However, such adjustments are difficult to make; see Joseph R. Antos, "The Role of Market Competition in Strengthening Medicare," testimony before the Senate Select Committee on Aging, May 6, 2003, *http://www.aei.org/publications/filter.all,pubID.17131/pub_detail.asp*; Michael J. O'Grady, "Health Insurance Spending Growth: How Does Medicare Compare?," Joint Economic Committee, June 10, 2003.

[17] Many of those efforts are discussed in Alice M. Rivlin and Joseph R. Antos (eds.), *Restoring Fiscal Sanity 2007: The Health Spending Challenge*, (Brookings Institution Press, forthcoming 2007).

STATEMENT OF JOHN GOODMAN, PRESIDENT, NATIONAL CENTER FOR POLICY ANALYSIS, DALLAS, TX

Mr. GOODMAN. Senator Kennedy, members of the committee, Professor Lawrence Kotlikoff, at Boston University, and his colleagues have done a 10-country study projecting spending into the future, based on the experience of the last 30 years, and projected aging of the populations. They have concluded that, by mid-century, when today's college students will be reaching retirement age, that government at all levels in the United States will be spending a third of the gross domestic product on health care, principally on Medicare and Medicaid. To put that into perspective, government at all levels today spends on all of its programs a third of the gross domestic product. So, we're on a course, by mid-century, for health care to literally crowd out everything else that government is doing.

Now, if the private sector keeps up with the government, and, for the last 30 years, it's done a good job of doing that, then, by mid-century, we would be spending two-thirds of the gross domestic product on health care. And to put that into perspective, two-thirds of GDP is roughly equal to all consumption on everything today. So, what we're talking about is a path that will take us, in another 50 years or so, to a point where there's nothing but health care—no food, no clothing, no housing. Not a pretty sight. And yet, that is the path that we are on. And this is a straightforward forecast, this isn't the type of thing that we see from the Medicare trustees, which, bad enough as it is, has a lot of hope for moderation involved. This is more consistent with the charts you'll see from the Congressional Budget Office and the Concord Coalition.

Now, what can be done about it? I don't have all of the answers, but I am confident that nothing we're hearing on the right or the left today is radical enough to seriously deal with the problem that we're looking at. I'm also confident that we're not going to get off the path we are on unless, on the demand side, somebody has to choose between health care and other uses of money. It can be government, it can be employers. It won't surprise most of you to know that I would like to see patients make as many of these decisions as possible. But somebody has to choose.

And on the supply side, we're not going to get off of this path unless we allow entrepreneurs to gain and make profits by finding ways to produce care more efficiently, as, for example, they're doing in the cosmetic surgery industry and in the laser surgery industry, where the real price of health care has actually been falling over the last decade.

Now, the path we are on is so overwhelming that, once you start thinking about it, it's hard to think about anything else. But, to the degree we do think about other things, I had an idea that I proposed to Ira Magaziner many years ago, and you didn't followup on it. And I took the same idea to Governor Romney, and he built a health care reform plan around it. And then, Governor Schwarzenegger took the same idea, but he added so many bells and whistles onto it that it's just not recognizable anymore. But the core idea was that we should take free health care dollars, our charity-care dollars, instead of having those dollars encourage people to drop their private coverage in order to get the free care, we should

use those dollars to subsidize people so that they could have private insurance instead.

I think, or I propose that we need no new spending, and Governor Romney agreed with me on this. There are enough dollars in the system right now. I don't think we need new mandates. He disagreed with me on that point. But the central idea was that the dollars should follow the people. And if they do, we eliminate perverse incentives for people to get care at taxpayer expense. I think the same principles also apply to Medicaid. And this is what's missing in the Massachusetts plan and in the California plan. You still have this huge incentive for people to drop their private coverage and get health care at taxpayer expense. That's not a socially good thing, in my opinion.

But the basic idea, to eliminate perverse incentives, let dollars follow people, and especially to give low-income people an opportunity to participate in the same health care system all the rest of us are participating in, that remains, I think, a good idea.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Goodman follows:]

PREPARED STATEMENT OF JOHN C. GOODMAN, PH.D.

Mr. Chairman and members of the committee, I welcome the opportunity to testify this morning about the challenges and opportunities related to health care coverage and access. I am John Goodman, President and CEO of the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector.

AN UNSUSTAINABLE PATH

Government at all levels in the United States currently spends about 7.2 percent of gross domestic product (GDP) on health care, mainly on Medicare and Medicaid. Yet Christian Hagist and Laurence J. Kotlikoff have shown that if benefits expand at the rate of the past 30 years and if the population ages the way demographers predict, government health care spending will equal one-third of national income by mid-century, when today's college students reach the retirement age.[1] If that is not immediately alarming, note that one-third of GDP is about equal to all government spending for all purposes today. If private spending on health care keeps up with public spending, the Nation will devote about two-thirds of national income to health care by mid-century—an amount roughly equal to the total consumption of all goods and services today.

So in the public sphere, health care is on a course to crowd out every other government program—from education and roads and bridges to Social Security and national defense. And for the economy as a whole, health care is on a course to crowd out every other form of consumption, including food, clothing, housing, etc.

Clearly we are on an impossible path. And the longer we stay on it, the more painful it will be to get off of it. Yet it is impossible to get off of it unless someone is forced to choose between health care and other uses of money. The question is: who will that someone be?

CHOOSING BETWEEN HEALTH CARE AND OTHER USES OF MONEY

Busy people are often unaware of how easy it is to spend other people's money on health care. Let me give you a few examples. The Cooper Clinic in Dallas offers an extensive checkup (with a full body scan) for about $2,000 or more. Its clients include Ross Perot, Larry King and other high-profile individuals. Yet if everyone in America took advantage of this opportunity, we would increase our Nation's annual health care bill by almost one-third. More than 1,000 diagnostic tests can be done on blood alone; and one doesn't need too much imagination to justify, say,

[1] Christian Hagist and Laurence J. Kotlikoff, "Health Care Spending: What the Future will Look Like," National Center for Policy Analysis, NCPA Policy Report No. 286, June 2006.

$6,500 worth of tests each year. But if everyone did so we would double the Nation's health care bill. Americans purchase nonprescription drugs almost 12 billion times a year and almost all of these are acts of self-medication. Yet if everyone sought professional advice before making such purchases, we would need 25 times the number of primary care physicians we currently have.[2] Some 1,100 tests can be done on our genes to determine if we have a predisposition toward one disease or another. At a conservative estimate of, say, $1,000 a test, it would cost more than $1 million for a patient to run the full gamut. But if every American did so, the total cost would run to about 30 times the Nation's annual output of goods and services.

Notice that in hypothetically spending all of this money we have not yet cured a single disease or treated an actual illness. We are simply collecting information. If in the process of searching we actually found something that warranted treatment, we could spend even more.

One of the cardinal beliefs of advocates of single-payer health insurance is that health care should be free at the point of consumption, regardless of willingness or ability to pay. But if health care really were free, people would have an incentive to obtain each and every service so long as it had any value at all to them. In other words, everybody would have at least an economic incentive to get the Cooper Clinic annual checkup, order dozens of blood tests, check out all their genes and consult physicians at the drop of a hat. In short order, unconstrained patients would attempt to spend the entire gross domestic product on health care even though, as a practical matter, that would be impossible.

To control the growth rate of health care spending, someone must choose between health care and other uses of money. That is, someone must decide that useful, beneficial health care procedures are not as valuable as other goods and services that could be purchased with the same funds. How can those decisions be made?

In principle there are only a limited number of ways choosing between health care and everything else. Three especially interesting approaches would have these choices made by: (a) government (national health insurance), (b) employers and insurers (managed care) or (c) patients in consultation with their doctors (consumer-driven health care).

Given the large number of devotees of all three approaches, you would think there would be a rich literature on how each allocates resources by comparing the costs and benefits of different types of care. In fact, the reverse is true. The very subject is virtually taboo.[3] Take positron emission tomography scanners, for example. At last count there were more than one thousand in the United States, but only three in Canada.[4] So how did Canada decide that the benefits of the 4th PET scanner (in terms of lives saved, diseases cured, etc.) was not worth the monetary cost? Is there some cost-benefit comparison in a paper or official document somewhere? None that I can find.

The PET scan example is not unique. Around the world, managers of government-run health care systems rarely discuss rationing decisions and how they are made.[5] The advocates of single-payer national health insurance are even worse. Scan their literature and you will search in vain for any discussion of how we should trade off health care benefits against monetary costs.[6]

The advocates of managed care are not much better. Think how many trees have been felled to support the huge volume of literature on this subject. But where in all this text is there a discussion of how managed care organizations are suppose to make cost-benefit tradeoffs? I have yet to find it.[7]

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[2] Simon Rottenberg, "Unintended Consequences: The Probable Effects of Mandated Medical Insurance," *Regulation*, Vol. 13, No. 2, Summer 1990, pages 27–28.

[3] An exception is John C. Goodman, Gerald L. Musgrave and Devon M. Herrick, *Lives at Risk: Single-Payer National Health Insurance Around the World* (Lanham, MD: Rowman & Littlefield, 2004).

[4] Of the 12 PET scanners in Canada, two are owned by private providers and seven are available only for research and clinical trials. See Laura Eggertson, "Radiologists, physicians push for PET scans," *Canadian Medical Association Journal*, Vol. 172, No. 13, June 21, 2005. Also see ; "What is PET?" Society of Nuclear Medicine, 2006.

[5] An exception is the Oregon Medicaid program, which prioritized 300 services and pledged to provide only those that the budget would allow. See Martin A. Strosberg, Joshua M. Wiener, Robert Baker and I. Alan Fein (editors) *Rationing America's Medical Care: The Oregon Plan and Beyond,* edited by (Washington, D.C.: The Brookings Institution, 1992).

[6] See Marcia Angell and the Physicians' Working Group, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance," Physicians for a National Health Program, August 13, 2003.

[7] There is of course a large and growing literature on cost effectiveness (e.g., how much does a procedure cost in terms of years of life saved?). These studies can serve as the basis for decisionmaking but they do not tell us how to make decisions.

Surprisingly, the advocates of consumer-driven health care (CDHC) are also reluctant to broach this subject. In fact, some of the most ardent supporters of Health Savings Accounts (HSAs) on Capitol Hill flatly deny that their purpose is to facilitate choices between health care and nonhealth care consumption. Indeed, this is the main reason why the law discourages people from removing their end-of-year HSA balances for nonhealth purposes.[8]

There is, however, this difference: Whether the supporters admit it or not, the United States is the first developed country to set up a formal, institutional mechanism that allows people to choose between health care and other uses of money on a rational basis.[9] As such, HSA accounts have the potential to revolutionize the health care system. Yet they will succeed in doing so only if they free patients to perform consumer functions that they have not been hitherto performing: (1) make tradeoffs between health care and other goods and services; (2) become savvy shoppers in the medical marketplace; and (3) become managers of their own care.

PATIENTS AS CHOOSERS

Critics of CDHC are fond of pointing out that there are times when patient choice is not desirable or appropriate. They are, of course, correct. We don't want a parent to choose not to have her child vaccinated, or an at-risk expectant mother to avoid prenatal care, or a heart patient to eschew aspirin or beta blockers. The reason: there is overwhelming evidence that the social benefits of the care exceed the social cost.[10] Yet instances where we can be absolutely sure that we know which alternative is the right choice are rarer than one might suppose. At the other extreme, there are literally thousands of cases where only the patient can make the right choice.

Take arthritic pain relief. The annual cost of brand-name drugs runs about $800 more than over-the-counter substitutes and they are riskier (Vioxx and Bextra, for example, have been removed from the market). Is the extra cost and risk worth the marginal improvement in pain relief offered by a prescription drug? Since drugs affect different people differently, we cannot determine for someone else whether the tradeoff is worthwhile. So it is appropriate and desirable for people to make these decisions themselves and reap the full benefits and bear the full costs of decisions they make.

The problem with the current system is that all too often patients have no opportunity to make such choices. The reason: most of the time they are buying health care with someone else's money. Ironically, most of the people who were taking Vioxx should not have been taking it; and the best predictor of whether a patient was taking it was whether a third-party was paying the bill.[11] This example is far from unique. For the health care system as a whole, patients pay only 14 cents out of pocket every time they spend a dollar, on the average. So the economic incentive is to spend on health care until its value to the patient is only 14 cents on the dollar. It's hard to imagine a more wasteful incentive structure.

With HSAs, people will not spend a dollar on health care services unless they get a dollar's worth of value. In this respect, HSAs greatly improve patients' incentives. If there is a problem, however, it is that the law is too rigid—requiring an across-the-board deductible for all services, other than preventive services. The answer to the critics is to allow plans to create high deductibles where the exercise of patient

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[8] Withdrawals for nonhealth purposes are subject to income taxes and a 10 percent penalty (before age 65). As a result, the tradeoff is not on a level playing field. For a family in the 25 percent tax bracket, $1 of health care trades against 65¢ of other goods, at least in the current period.

[9] Note, however, that South Africa's Medical Savings Accounts were introduced more than a decade ago and Singapore's medisave accounts are now two decades old. See Shaun Matisonn, "Medical Savings Accounts in South Africa," National Center for Policy Analysis, NCPA Policy Report No. 234, June 2000; Thomas A. Massaro and Yu-Ning Wong, "Medical Savings Accounts: The Singapore Experience," National Center for Policy Analysis, NCPA Policy Report No. 203 April 1996.

[10] See Tammy O. Tengs et al., "Five-Hundred Life-Saving Interventions and Their Cost-Effectiveness," *Risk Analysis*, Vol. 15 No. 3, 1995; and David M. Eddy (editor), *Common Screening Tests*, (Philadelphia: American College of Physicians, 1991).

[11] A recent study found that two-thirds of patients on COX−2 inhibitors were not at risk for gastrointestinal conditions like ulcers or bleeding, and most of them had not tried cheaper alternatives. See Emily R. Cox et Al., "Prescribing COX−2s for Patients New to Cyclo-oxygenase Inhibition Therapy," *American Journal of Managed Care*, Vol. 9, No. 11, pp. 735–42, November 2003. A separate study found that seniors with generous drug coverage but moderate risk of gastrointestinal problems were more likely to be on a COX−2 inhibitor than seniors with high gastrointestinal risk but no drug coverage. See Jalpa A. Doshi, Nicole Brandt and Bruce Stuart, "The Impact of Drug Coverage on COX−2 Inhibitor Use In Medicare," *Health Affairs*, Web Exclusive W4-94, February 18, 2004.

discretion is both possible and desirable and create low deductibles where discretion is not possible or, in any event, not desirable.

How do patients react when they are asked to manage their own health care dollars? We actually have far more experience with consumer-directed health care than many scholars realize. For example, we have more than a decade of experience with Medical Savings Accounts (MSAs) in South Africa, and in this country 7 years experience with the MSA pilot program, 4 years of experience with Health Reimbursement Arrangements (HRAs) and 2½ years with HSAs. The problem is: the data mainly resides with insurers who regard it as proprietary and, therefore, the results are reported by entities with a financial self-interest in the outcomes.

Even so, reported results of MSAs in South Africa (Discovery Health)[12] and HRAs in the United States (Aetna)[13] are consistent with common sense. Patients cut back in areas where there is presumed to be a lot of waste and substitute less expensive treatment options for more expensive ones. That is, there are fewer trips to primary care physicians; brand-name drug purchases are down; generic purchases are up, etc. These findings were also evident in an Employee Benefit Research Institute study.[14] Consumers were more cost-conscious—about one-third of consumers with high-deductible or consumer-driven health plans avoided or delayed seeking care.

A McKinsey study (based on a year's experience with HSAs) found that CDHC patients were twice as likely as patients in traditional plans to ask about cost and three times as likely to choose a less expensive treatment option. Further, chronic patients were 20 percent more likely to follow treatment regimes very carefully.[15] A South African study suggests that CDHC patients can control drug costs as well as managed care, but without the cost of managed care.[16]

Early critics of CDHC worried adverse selection of young, healthy workers would destroy traditional risk pools. Yet there is no evidence that CDHC attracted disproportionate numbers of young people. When adjusted for retirees who were not eligible, a recent GAO report of government workers found those joining CDHC plans were about the same age as enrolling in more traditional plans.[17] Two additional GAO reports came to similar conclusions.[18] A recent survey by the health insurance industry trade group found adult enrollees evenly distributed with nearly one-quarter between the age of 40 and 49 and one quarter above that age group and one-quarter below.[19]

Assurant Health (formerly Fortis) reported on its enrollees with health savings accounts in 2005. It found:[20]

- Nearly one-third (30 percent) had less than $50,000 annually in family income.
- About 44 percent had previously been uninsured shortly before obtaining an HSA.
- More than half (61 percent) were older than age 40.
- More than two-thirds (69 percent) were families with children.

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[12] Matisonn, "Medical Savings Accounts in South Africa."

[13] "Aetna HealthFund First-Year Results Validate Positive Impact of Health Care Consumerism," Press Release, Aetna, June 24, 2004.

[14] Paul Fronstin, and Sara R. Collins, "Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey," Employee Benefit Research Institute, Issue Brief No. 288, December 2005.

[15] Consumer-Directed Health Plan Report—Early Evidence Is Promising," McKinsey & Company, North American Payor Provider Practice, June 2005.

[16] Shaun Matisonn, "Medical Savings Accounts and Prescription Drugs: Evidence from South Africa," National Center for Policy Analysis, NCPA Policy Report No. 254, August 2002.

[17] GAO, "Federal Employees Health Benefits Program: Early Experience with a Consumer-Directed Health Plan," U.S. Government Accountability Office, Publication GAO-06-143, November 2005.

[18] GAO, "Federal Employees Health Benefits Program: First-Year Experience with High-Deductible Health Plans and Health Savings Accounts," U.S. Government Accountability Office, Publication GAO-06-271, January 2006; GAO, "Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Plans," U.S. Government Accountability Office, Publication GAO-06-798, August 2006.

[19] Hannah Yoo and Teresa Chovan, "January 2006 Census Shows 3.2 Million People Covered By HSA Plans," America's Health Insurance Plans, AHIP Center for Policy and Research, 2006.

[20] "*Who's Taking Advantage of Health Savings Accounts (HSAs)?*" Assurant Health Quick Facts, 2006. Available. Internet. http://www.assuranthealth.com/corp/ah/AboutAssurantHealth/HSAFactSheet.htm. Accessed September 22, 2006.

The results on enrollee satisfaction have been mixed. A recent GAO report found strong satisfaction[21] as did reports by Lumenos[22] and Aetna.[23] However, reports by McKinsey and EBRI reported lower satisfaction than those enrolled in traditional health plans.[24] It's not clear what this means. A study in the Annuals of Internal Medicine found satisfactions is not related to quality.[25] In fact, this phenomenon is not uncommon among consumer goods. Satisfaction is generally more closely related to good communication and met expectations.[26] Moreover, surveys where enrollees rate their CDHP lower than managed care may be sampling unrepresentative enrollees or people who perceived they've lost benefits when switched to a full-replacement CDHC plan.[27] Or it may point to the need to have better consumer education and about the merits and uses of the plans in addition to greater price transparency.[28]

What about preventive care? McKinsey, Aetna, National Center for Policy Analysis (Discovery Health) and Humana[29] all report an increase in preventive care—even as they report other, significant cost-reducing changes in patient behavior. Note, however, that many CDHC plans contain extra incentives to seek and obtain preventive care. Discovery Health tried to determine whether skimping on care in the short run caused higher costs in later years and found no evidence to support the claim.[30]

CREATING OPPORTUNITIES FOR THE CHRONICALLY ILL[31]

The chronically ill are responsible for an enormous amount of health care spending. In fact, almost half of all health care dollars are spent on patients with five chronic conditions (diabetes, heart disease, hypertension, asthma and mood disorders). This is where HSAs have the greatest potential to reduce costs and improve the quality of care.

Healthy people tend to interact with the health care system episodically. Once in awhile they go to the emergency room or take a prescription drug. On these occasions, they gain knowledge that improves their skills as medical consumers. But it may be several years before they use that knowledge again, by which time it may be obsolete.

The chronically ill are different. Their treatments are usually repetitive, requiring the same procedures, visits and/or medicines, week after week, year after year. Consequently, cost-saving discoveries by these patients are not one-time events. Rather, they pay off indefinitely. Suppose a diabetic patient learns how to cut the costs of her drugs in half, by comparing prices, shopping online, bulk buying, pill splitting or switching to a generic brand. Such a discovery could be financially very rewarding to a patient who must pay these costs out-of-pocket.

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[21] GAO, "Consumer-Directed Health Plans: Early Enrollee Experiences with Health Savings Accounts and Eligible Plans," U.S. Government Accountability Office, Publication GAO-06-798, August 2006.

[22] "Survey Reveals Lumenos Customers More Satisfied than Members of Traditional Health Plans," Press Release, Lumenos, 2004.

[23] About 90 percent of enrollees said plan met expectations and would enroll again. See "Aetna HealthFund Fact Sheet," Aetna, 2006. Available at *http://www.aetna.com/presscenter/kit/aetna_healthfund/healthfund_factsheet.html*. Accessed September 22, 2006.

[24] Paul Fronstin, and Sara R. Collins, "Early Experience with High-Deductible and Consumer-Driven Health Plans: Findings from the EBRI/Commonwealth Fund Consumerism in Health Care Survey," Employee Benefit Research Institute, Issue Brief No. 288, December 2005. "Consumer-Directed Health Plan Report—Early Evidence Is Promising," McKinsey & Company, North American Payor Provider Practice, June 2005.

[25] John T. Chang, "Patients' Global Ratings of Their Health Care Are Not Associated with the Technical Quality of Their Care," *Annals of Internal Medicine*, Vol. 144, No. 9, May 2, 2006.

[26] Holman W. Jenkins, "No, Consumer Theory Isn't a Cure-all for Health Care," *Wall Street Journal*, September 20, 2006.

[27] Devon Herrick, "Experts Doubt Survey Findings on Health Plan Owners' Satisfaction," *Health Care News*, February 1, 2006.

[28] "Brokers Predict Massive Change: Results from the 2006 NAHU/Chapter House Benefit Buying Trends Study," National Association of Health Underwriters/Charter House, 2006.

[29] "Healthcare Consumers: Passive or Active?" Humana, June 28, 2005.

[30] Refuting the criticism that the reduction in spending reflects MSA holders' tendency to forgo appropriate health care would require a randomized longitudinal study with far more clinical data than is currently available. However, a comparison of catastrophic claims under the two different health plans did not show more catastrophic claims under the MSA plan than under the non-MSA plan. Apparently MSA-holders are not healthier as a group. See Shaun Matisonn, "Medical Savings Accounts in South Africa," National Center for Policy Analysis, NCPA Policy Report No. 234, June 2000.

[31] John C. Goodman, "Making HSAs Better," National Center for Policy Analysis, Brief Analysis No. 518, June 30, 2005.

Numerous studies have found the chronically ill can reduce costs and improve quality by managing their own care. But health care management is difficult and time-consuming. So patients should reap both health rewards and financial rewards from making better decisions. Insurers should be able to create versatile HSA accounts for patients with differing chronic conditions. They should be able to adjust the accounts' funding to fit specific circumstances. A typical Type II diabetic, for example, might receive one level of HSA deposit from his employer; a typical asthmatic patient another.

The problem is: The HSA law requires employers to deposit the same amount to each employee's HSA account, irrespective of medical condition. This is a strange requirement because employers who give employees choices of health plans are risk-rating their premium payments whether they are aware of it or not. If the sickest employees all choose Plan B and the healthiest choose Plan A, then the employer will invariably pay more premiums per employee to Plan B. Although employers risk-rate their premium payments, they are not allowed to risk-rate HSA deposits.

I have attached two articles for your benefit that also address the challenges and opportunities related to health care coverage and access. The first is "Solving the Problem of the Uninsured" from *Thoracic Surgery Clinics*. The second is "What Is Consumer-Directed Health Care?" from *Health Affairs Online*.

Solving the Problem of the Uninsured*

The fact that millions of Americans do not have health insurance is said to be a major problem, if not the major problem, of the United States health care system. Estimates of the number who are uninsured vary widely. There are also widely different indicators of how much difference uninsurance makes. Proposed solutions range from single-payer national health insurance to individual or employer mandates to tax subsidies for the purchase of private health insurance. Even the proponents admit these proposals require large taxpayer burdens and new Federal bureaucracies.

Fortunately, there is a way to deal with this problem that does not require new taxes or cumbersome (and probably unenforceable) mandates. Nor does the solution require the knowledge of how many uninsured there are at any one time or what difference uninsurance makes. The solution involves integrating the current system of tax subsidies (which encourage people to obtain private insurance) with the system of spending subsidies (which encourage people not to be insured). The purpose of the integration is to ensure that government policies are not encouraging people to be uninsured, and causing the very problem that needs to be solved.

All physicians are familiar with the do-no-harm principle in medical ethics. It is time to apply that same principle to public policy.

Nature of the Problem

The latest Census Bureau report estimates that 45 million Americans are uninsured at any one time.[1] Yet, estimates using the Census Bureau's Survey of Income and Program Participation suggest that the actual number of uninsured could be half as large. For instance, a Congressional Budget Office study of the Census Bureau's Survey of Income and Program Participation estimated the actual number of uninsured may be as low as 21 million.[2] Another report finds that, even using Census Bureau methods, the 45 million number is about 25 percent too high, or off by 9 million people.[3]

Regardless of the actual number, what is more important is how long people are uninsured. Being uninsured is like being unemployed. Most people probably experience the condition over the course of a lifetime, but in most cases it is temporary. Very few people are uninsured for a long period of time. For instance, 75 percent of uninsured spells are over within 12 months. Less than 10 percent last longer than 2 years.[4]

There are dozens of studies that claim to find significant health differences between those who are insured and those who are uninsured. For instance, Marquis and Long[5][6] find that uninsured adults have about 60 percent as many physician visits and 70 percent as many inpatient hospital days as they would if they were covered by insurance. Yet, there are reasons to doubt these results. Consider the fact that there are between 10 and 14 million people who are theoretically eligible for Medicaid and SCHIP (for low-income families who do not qualify for Medicaid) but do not bother to sign up. This is almost one in every four uninsured persons

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*The original title was modified to this version by the request of the Guest Editor, Dr. Sade.
E-mail address: jcgoodman@ncpa.org.

in the country. Estimates of eligibility for public health care programs vary. The lower estimates are that around 10 million Americans are eligible but unenrolled, whereas the upper range of estimates is closer to 14 million. One study found that just over half (51.4 percent) of eligible, nonelderly adults were enrolled in Medicaid in 1997. Of the remaining adults who were Medicaid eligible, 21.6 percent had private coverage, whereas 27 percent were uninsured. Another study found that about 7 million uninsured children eligible for either SCHIP or Medicaid are not enrolled.[7] Of those children eligible for Medicaid or SCHIP, one third is eligible for SCHIP, whereas two-thirds are eligible for Medicaid. Eight percent of uninsured, low-income children are illegal aliens and, as such, not eligible for either Medicaid or SCHIP.[8 9] Furthermore, in most places people are able to enroll in Medicaid up to 3 months after they receive medical treatment. Because these people can enroll at the drop of a hat, even after they have incurred medical expenses, are they not *de facto* insured even without the necessity of formal enrollment?

To see what this means on the local level, consider Parkland Hospital in Dallas, a primary source of care for the indigent and those covered by Medicaid. Uninsured patients and Medicaid patients pass through the same emergency room door; they see the same doctors; they receive the same treatments; and if required, they are admitted to hospital rooms on the same floors.[10]

The only people who seem to care very much about who is insured or uninsured at Parkland are the hospital staff (presumably because that affects how they get paid). For that reason, full-time employees work their way through the emergency room waiting area to enroll all eligible patients in Medicaid (most of the time they fail). With the same goal in mind, employees also go room to room to visit those who are admitted (where their success rate is much higher).

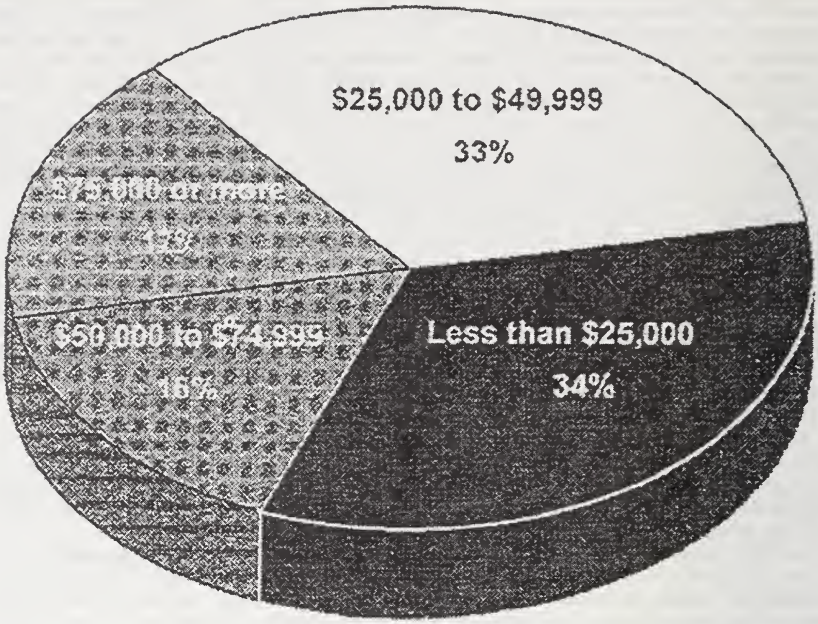
At Children's Medical Center, next door to Parkland, a similar exercise takes place. Children on Medicaid, children on SCHIP, and uninsured children all come through the same emergency room door. Again, they all see the same doctors and receive the same treatments. Again, it is only the hospital that seems to care whether anybody is insured and by whom.[10]

If a $100 bill were dropped on the emergency room floor at Parkland, it probably would not remain there for 60 seconds; but an application to enroll in Medicaid dropped on the same floor might remain there for hours. In the view of some commentators, the enrollment forms are a ticket to health insurance worth thousands of dollars and substantially more health care. But people do not act as though they believe that is the case. To the contrary, they act as though the marginal value of enrollment is virtually zero.

For the millions of people who opt not to enroll in free government-provided health insurance, uninsurance is the result of voluntary choice. A lot of other people are also voluntarily uninsured. For example, about 9 million people (more than one in five of the uninsured) are eligible for employer insurance and decline to enroll even though the employee share of the premium is usually nominal.[11]

It can be inferred that many other people are voluntarily uninsured, because they apparently have enough income to purchase insurance if they choose. Although it is common to think of the uninsured as having low incomes, many families who lack insurance are solidly middle class (Fig. 1). The largest increase in the number of uninsured in recent years has occurred among higher-income families, About one in three uninsured persons (14.8 million people) lives in a family with an income of $50,000 or higher and about half of those have incomes in excess of $75,000. Further, over the past decade, the number of uninsured increased by 54 percent in households earning between $50,000 and $75,000 and by 130 percent among households earning $75,000 or more. By contrast, in households earning less than $50,000 the number of uninsured decreased approximately 3 percent.[12]

These results are contrary to the normal expectation of economists. Economic theory teaches that as people earn higher incomes, they should be more willing to purchase insurance to protect their income against claims arising from expensive medical bills.



Similarly, as people become wealthier the value of insuring against wealth depiction (e.g., by a catastrophic illness) also rises. Insurance should be positively correlated with income and wealth accumulation. The fact that the number of uninsured rose over the past decade while incomes were rising and that the greatest increase was among higher-income families suggests that something else is happening to make insurance less attractive.

Some information about middle-class families who are voluntarily uninsured is provided by a California survey of the uninsured with incomes of more than 200 percent of poverty.[13] Forty percent owned their own homes and more than half owned a personal computer. Twenty percent worked for an employer that offered health benefits, but half of those declined coverage for which they were eligible. This group was not opposed to insurance in general, however, because 90 percent had purchased auto, home, or life insurance in the past.

The existence of voluntary uninsurance raises a profound public policy question. Economists assume that if people choose A rather than B they are revealing through their actions that they prefer A to B. Further, if people act in accordance with their preferences one is entitled to say they are better off from their own point of view.

From the economist's perspective, the case for doing something about the uninsured rests on its effects on people other than the uninsured. External effects, as shown below, are quite substantial; but if the goal of the reform is to minimize external costs for others, the reform looks quite different from a reform that focuses on the uninsured.

POLICY PROPOSALS

A number of proposals seek to reduce or eliminate the problem of uninsurance. For example, Physicians for a National Health Program proposes a system of taxpayer-funded, free health care, making government the universal insurer of everyone.[14] Both major candidates in the 2004 presidential campaign proposed offering tax subsidies for private insurance, to individuals and to employers. All of these proposals are highly expensive relative to any reasonable estimate of their probability of success in insuring the uninsured. For example, the National Center for Policy Analysis estimated that Senator John Kerry's plan would have cost just over $1 trillion over 10 years.[15] An American Enterprise Institute study placed the cost of the Kerry plan at $1.5 trillion and President Bush's plan at $128.6 billion. This results in a cost of $1,919 per newly insured individual for the Bush plan (almost $8,000 for a family of four) and $5,494 for the Kerry plan (almost $22,000 for a family of

four). Using the candidates' own figures, the Bush plan would have cost $1,667 per newly insured, whereas the Kerry plan would have cost about double that amount.[16] [17]

A different approach is to require individuals to purchase insurance (much as it is now required that people who drive a car have a driver's license) or to require employers to insure their own employees. Proposals to impose mandates on the private sector typically offer a pay-or-play option: either provide insurance or pay a sum of money to the government and let the government handle the problem. There are many problems with mandates, but the most important problem is this: with a pay-or-play approach, no mandate is actually needed.

To the advocates of mandates, the question can always be asked: What are you going to do with people who disobey the mandate? As a practical matter, no one is suggesting that they be put in jail. One is left with imposing a financial penalty (e.g., a fine). But a system that fines people who are uninsured ipso facto is indistinguishable from a system that subsidizes those who insure, the subsidy being the absence of the fine. That is the system already in place.

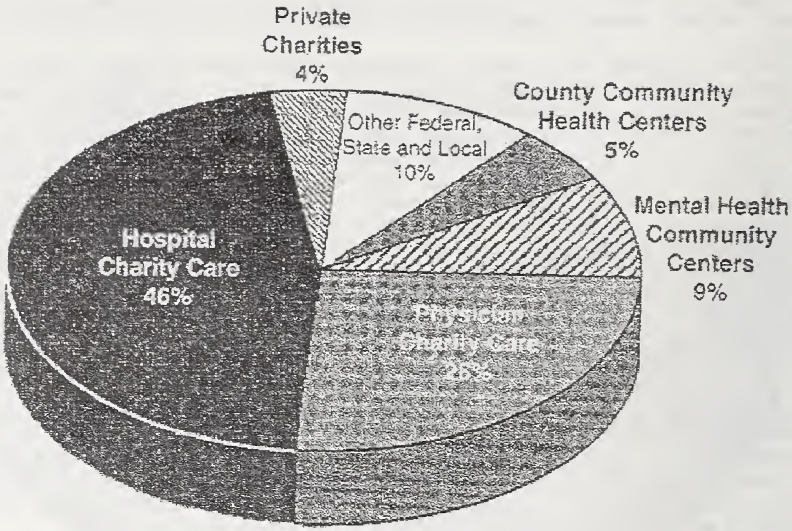
REASONS FOR UNINSURANCE

Although most people in health policy believe that the existence of millions of uninsured people is a major public policy problem, politicians at both the State and Federal level are reflecting voter indifference through their failure to act. The probable reason for this indifference is that uninsured families discover how to get health care even if they have no insurance. They do so in one of two ways: they manage to get insurance after they get sick or they manage to get free care.

A proliferation of State laws has made it increasingly easy for people to obtain insurance after they get sick. Guaranteed issue regulations (requiring insurers to take all comers, regardless of health status) and community-rating regulations (requiring insurers to charge the same premium to all enrollees, regardless of health status) are a free rider's heaven. They encourage everyone to remain uninsured while healthy, confident that they will always be able to obtain insurance once they get sick. Moreover, as healthy people respond to these incentives by electing to be uninsured, the premium that must be charged to cover costs for those who remain in insurance pools rises. These higher premiums, in turn, encourage even more healthy people to drop their coverage.

Federal legislation has also made it increasingly easy to obtain insurance after one gets sick. The Health Insurance Portability and Accountability Act of 1996 had a noble intent to guarantee that people who have been paying premiums into the private insurance system do not lose coverage simply because they change jobs. A side effect of pursuing this desirable goal is a provision that allows any small business to obtain insurance regardless of the health status of its employees. This means that a small, mom-and-pop operation can save money by remaining uninsured until a family member gets sick. Individuals can also opt out of their employer's plan and re-enroll after they get sick (they are entitled to full coverage for a pre-existing condition after an 18-month waiting period). A group health plan can apply pre-existing condition exclusions for no more than 12 months except in the case of late enrollees to whom exclusions can apply for 18 months.

The other lure is the existence of free care for those who cannot or do not pay their medical bills. Although no one knows what the exact number is, public and private spending on free care is considerable. A study by the Texas State Comptroller's office found that Texas spent about $1,000 per year on free care for every uninsured person in the State, on the average (Fig. 2).[18] A less comprehensive, but nonetheless nationwide, study by the Urban Institute estimated that in 2001 the uninsured received nearly $90 billion in care, of which more than one third was uncompensated charity care. Charity care by this calculation was equal to about $767 per uninsured individual. If uncompensated physician care is included (as it was in the Texas study), the total likely approaches $1,000.[19]



The Texas estimate is almost 7 years old, and at an annual (health care) rate of inflation of 10 percent, spending doubles every 7 years. Assuming a more conservative increase of 50 percent puts spending on the uninsured at almost $1,500 per person, or about $6,000 a year for a family of four.

Interestingly, $6,000 is a sum adequate to purchase private health insurance for a family in most Texas cities. One way to look at the choice many Texas families face is: they can rely on $6,000 in free care (on the average) or they can purchase a $6,000 private insurance policy with after tax income. Granted, the two alternatives are not exactly comparable. Families surely have more options if they have private insurance. To many, however, the free care alternative seems more attractive.

RATIONALE FOR GOVERNMENT

Aside from the burden of providing charity care to the poor, is there any legitimate reason for government to care whether people have health insurance? Although many reasons have been offered, the main and by far the most persuasive is the "free rider" argument. According to this argument, health insurance has social benefits, over and above the personal benefits to the person who chooses to insure. The reason is that people who fail to insure are likely to get health care anyway, even if they cannot pay for it, because the rest of the community is unwilling to allow the uninsured to go without health care, even if their lack of insurance is willful and negligent.

This set of circumstances creates opportunities for some people to be free riders on other people's generosity. In particular, free riders can choose not to pay insurance premiums and to spend the money on other consumption instead, confident that the community as a whole will provide them with care even if they cannot pay for it when it is needed. Being a free rider works because there is a tacit community agreement that no one will be allowed to go without health care. This tacit agreement is so established that it operates as a social contract that many people substitute for a private insurance contract.

A PROPOSAL FOR REFORM

Fortunately, the concerns of the free rider argument can be met without the disadvantage of other reform proposals. There can be a system that provides a reasonable form of universal coverage for everyone without spending more money and without intrusive and unenforceable government mandates.

Changing the tax system

Currently, the Federal Government spends more than $189 billion a year on tax subsidies for private insurance.[20] The bulk of these subsidies arise from the fact that employer payments for employee health care are excluded from taxable em-

ployee income. Because State tax laws tend to piggyback on the Federal tax system, these employer payments avoid State income and payroll taxes. Consider a middle-income family facing a 25 percent Federal income tax rate; a (employer and employee combined) payroll tax rate of 15.3 percent; and a State income tax of, say, 4 percent, 5 percent, or 6 percent. The ability to exclude employer-paid premiums from taxation means that government is paying almost half the cost of the family's insurance.

These generous tax subsidies undoubtedly encourage people who would otherwise be uninsured to obtain employer-provided insurance. There are three problems, however, with these tax subsidies the way they are structured: (1) the largest subsidies are given to people who need them least; (2) the subsidies are generally not available to most of the uninsured; and (3) the penalties for being uninsured do not fund safety net care.

Under the current system, families who obtain insurance through an employer obtain a tax subsidy worth about $1,482 on the average.[20] Not everyone, however, gets the average tax subsidy. Households earning more than $100,000 per year receive an average subsidy of $2,780. By contrast, those earning between $20,000 and $30,000 receive only $725 (Fig. 3). One reason is that those earning higher incomes are in higher tax brackets. For example, a family in the 40 percent tax bracket gets a subsidy of 40 cents for every dollar spent on their health insurance. By contrast, a family in the 15 percent bracket (paying only the FICA payroll tax) gets a subsidy of only 15 cents on the dollar.

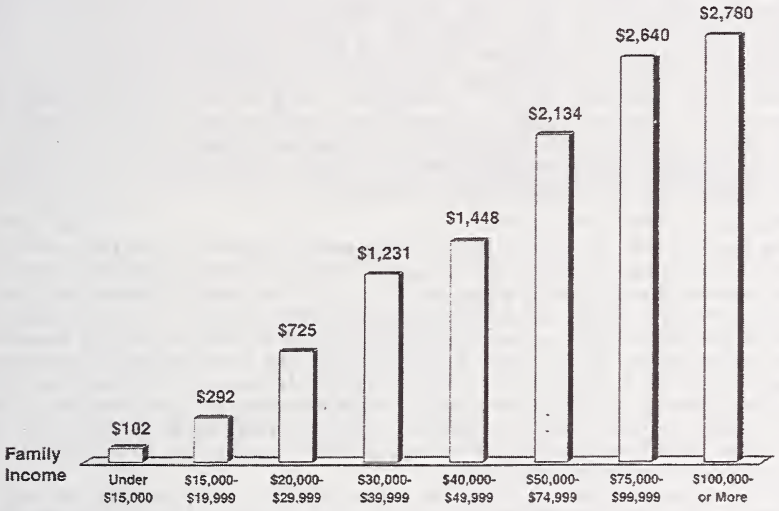


Fig. 3. Average tax subsidy for families, 2004. Lewin Group estimates using the Health Benefits Simulation Model. Average per family is $1482. Includes subsidy from the income tax exclusion, the Social Security income tax exclusion, and the health expenses deduction. (*From* Sheils J, Haught R. The cost of tax-exempt health benefits in 2004. Health Aff (Millwood) Web Exclusive, February 25, 2004. Available at http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.106v1. Accessed July 24, 2005.)

The second problem is that people who do not obtain insurance through an employer get virtually no tax relief if they purchase insurance. Individuals paying out-of-pocket for health care can deduct costs in excess of 7.5 percent of adjusted gross income. For instance, a family with $50,000 in income is not able to deduct the first $3,750 in medical expenses.[21] This means that a middle-income family buying insurance directly must pay almost twice as much after taxes as a similarly situated family whose employer is able to buy the same insurance with pretax dollars. Because most of the uninsured are in this situation, small wonder that reliance on a (free care) safety net looms as an attractive alternative.

Because an uninsured family with an average income does not get a tax subsidy, the family pays about $1,482 more in taxes than families that have employer-provided insurance. Instead of describing the current system as one that subsidizes

employer-provided insurance, it could, with equal validity, be described as one that penalizes the lack of employer-provided insurance.

Any incentive system can be described in one of two ways: as a system that grants subsidies to those who insure and withholds them from those who do not; or as a system that penalizes the uninsured and refrains from penalizing the insured. Either description is valid, because a subsidy is simply the mirror image of a penalty.

Under the current system the uninsured pay higher taxes because they do not enjoy the tax relief given to those who have employer-provided insurance. These higher taxes are a "fine" for being uninsured. The problem is that the extra taxes paid are simply lumped in with other revenues collected by the U.S. Treasury Department, whereas the expense of delivering free care falls to local doctors and hospitals.

How can these defects be corrected? First, a uniform, refundable tax credit should be offered to every individual for the purchase of private insurance. The Bush administration has proposed a $1,000 per person refundable tax credit, or $3,000 per family. This tax credit phases out as income rises, however, and virtually vanishes when family income reaches about $80,000 (the author helped formulate the administration's proposal). In general, social interest in whether someone is insured is largely independent of income. In general, a $100,000-a-year family can generate hospital bills it cannot pay almost as easily as a $30,000-a-year family. One can readily grant that there is no social reason to care whether Bill Gates is insured. There could be an income or wealth threshold, beyond which the subsidy-penalty system does not apply. As a practical matter, however, there are so few individuals who would qualify for an exemption that uniform treatment for everyone is administratively attractive. For this reason and practical considerations, the tax credit should be independent of income. Second, all forms of private insurance should be subsidized at the same rate. There is no socially good reason why individuals who cannot obtain insurance through an employer should be penalized when they buy insurance on their own. Third, the higher taxes paid by people who turn down the offer of the tax credit (and through that act elect to be uninsured) should flow to local communities where the uninsured live to be available to pay for care that uninsured patients cannot afford to pay on their own.

Changing the Social Security net

The problem with the current system of spending subsidies is that they encourage people to be uninsured. Why pay for expensive private health insurance when free care provided through public programs is *de facto* insurance? Think of the system that provides free health care services as "safety net insurance," and note that reliance on the safety net is not as valuable to patients as ordinary private insurance, other things equal. The privately insured patient has more choices of doctors and hospital facilities. Further, safety net care is probably much less efficient (e.g., using emergency rooms to provide care that is more economic in a free-standing clinic). As a result, per dollar spent the privately insured patient probably gets more care and better care. It is in society's interest not to encourage people to be in the public sector rather than the private sector.

To avert the perverse incentives the current system creates, people who rely on the free care system should be able to apply those dollars instead to the purchase of private insurance and the accompanying private health care that private insurance makes possible. A mechanism for accomplishing this result follows.

Integrating taxing and spending decisions

Let us now put the pieces together.[22 23] Under an ideal system, the government offers every individual a subsidy. If the individual obtained private insurance, the subsidy is realized in the form of lower taxes (in the form of a tax credit). Alternatively, if the individual chose to be uninsured, the subsidy is sent to a safety net agency in the community where the individual lives (Fig. 4).

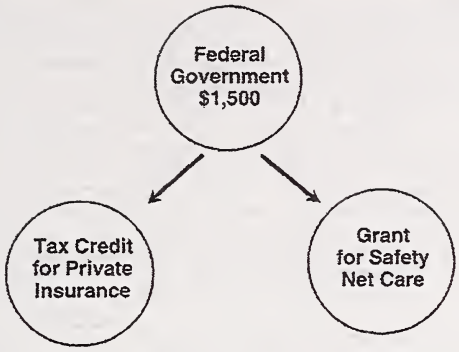


Fig. 4. The $1500 federal guarantee.

The uniform subsidy should reflect the value society places on having one more person insured. But what is that value? An empirically verifiable number is at hand, so long as one is willing to accept the political system as dispositive. It is the amount one expects to spend (from public and private sources) on free care for that person when he or she is uninsured. For example, if society is spending $1,500 per year on free care for the uninsured, on the average, one should be willing to offer $1,500 to everyone who obtains private insurance. Failure to subsidize private insurance as generously as free care is subsidized encourages people to choose the latter over the former.

One way to think of such an arrangement is to see it as a system under which the uninsured as a group pay for their own free care. That is, in the very act of turning down a tax credit (by choosing not to insure) uninsured individuals pay extra taxes equal to the average amount of free care given annually to the uninsured (Fig. 5).

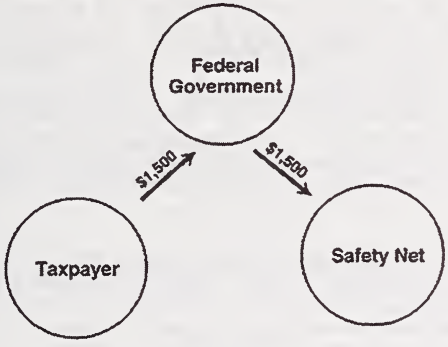


Fig. 5. The marginal effect of choosing to be uninsured.

How can the subsidies for those who choose to move from being uninsured to insured be funded? By reversing the process: at the margin, the subsidy should be funded by the reduction in expected free care that person would have consumed if uninsured. Suppose everyone in Dallas County chose to obtain private insurance, relying on a refundable $1,500 Federal income tax credit to pay the premiums. As a result, Dallas County no longer needs to spend $1,500 per person on the uninsured. All of the money that previously funded safety net medical care could be used to fund the private insurance premiums (Fig. 6).

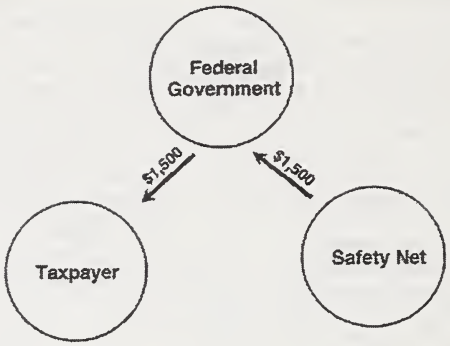


Fig. 6. The marginal effect of choosing to be insured.

In this way, people who leave the social safety net and obtain private insurance actually furnish the funding needed to pay their private insurance premiums, at least at the margin. They do this by allowing public authorities to reduce safety net spending by an amount equal to the private insurance tax subsidy. Some patients may be high cost. In a private insurance market, insurers do not agree to insure someone for $1,000 if his or her expected cost of care is, say, $5,000. But if the safety net agency expects a $5,000 savings as a result of the loss of a patient to a private insurer, the agency should be willing to pay up to $5,000 to subsidize the private insurance premium, The additional, higher subsidy could be incorporated into the tax credit or added as a supplement to the tax credit.

Implementing reform

How can this scheme be implemented? To implement the program, all the Federal Government needs to know is how many people live in each community. In principle, it is offering each of them an annual $1,500 tax credit. Some will claim the full credit. Some will claim a partial credit (because they will only be insured for part of a year). Others will claim no credit. What the government pledges to each community is $1,500 times the number of people. The portion of this sum that is not claimed on tax returns should be available as block grants to be spent on indigent health care.

How does the Federal Government manage to reduce safety net spending when uninsured people elected to obtain private insurance? Because much of the safety net expenditure already consists of Federal funds, the Federal Government could use its share to fund private insurance tax credits instead. For the remainder, the Federal Government could reduce block grants to States for Medicaid and other programs.

Advantages of reform

The goal of health insurance reform is not to get everyone insured (indeed, everyone is already in a loose sense insured). Instead, the goal is to reach a point at which there is societal indifference about whether one more person obtains private insurance as an alternative to relying on the social safety net. That is the point at which the marginal cost (in terms of subsidy) to the remaining members of society of the last person induced to insure is equal to the marginal benefit to the remaining members of society (in terms of the reduction in cost of free care). Once this condition is satisfied, it follows that the number of people who remain uninsured is optimal, and that number is not zero.

This is achieved by taking the average amount spent on free care and making it available for the purchase of private insurance. In the previous example, the government guarantees that $1,500 is available, depending on the choice of insurance system. From a policy perspective, there is indifference about the choice people make.

A common misconception is that health insurance reform costs money. For example, if health insurance for 40 million people costs $1,500 a person, some conclude that the government needs to spend an additional $65 billion a year to get the job done. What this conclusion overlooks is that $65 billion or more is already being spent on free care for the uninsured, and if all 40 million uninsured suddenly became insured they would free up the $65 billion from the social safety net.

At nearly $2 trillion a year,[24] there is no reason to believe the health care system is spending too little money. To the contrary, attempting to insure the uninsured by spending more money has the perverse effect of contributing to health care inflation. Getting all the incentives right may involve shifting around a lot of money (i.e., reducing subsidies that are currently too large and increasing subsidies that are too small). It may also mean making some portion of people's tax liability contingent on proof of insurance.[25] It need not add to budgetary outlays.

There is virtually nothing in the tax code about what features a health insurance plan must have to qualify for a tax subsidy. The exceptions are mandated maternity coverage and coverage of a 48-hour hospital stay after a well-baby delivery if requested by a patient and physician. Insurance purchased commercially, around two-thirds of the total, is regulated by the State governments. But the Federal tax subsidy applies to whatever plans State governments allow to be sold.[26] In this sense, the Federal role is strictly financial. That is, the current tax break is based solely on the number of dollars taxpayers spend on health insurance, not on the features of the health plans themselves.

This practice is sensible and should be continued. Aside from an interest in encouraging catastrophic insurance, there is no social reason why government at any level should dictate the content of health insurance plans. To continue the example, the role of the Federal Government should be to ensure that $1,500 is available. It should leave the particulars of the insurance contract to the market, and it should leave decisions about how to operate the safety net health care to local citizens and their elected representatives.

Under the current system, when people lose or drop their employer-provided insurance coverage, the Federal Government receives more in taxes as a result. But it makes no extra contribution to any local health care safety net. As a consequence, the growth in the uninsured is straining the finances of many urban hospitals. The problem is exacerbated by less generous Federal reimbursement for Medicaid and Medicare and by increasing competitiveness in the hospital sector, Traditionally, hospitals have covered losses that arise from people who cannot pay for their care by overcharging those who can pay. But as the market becomes more competitive, these overcharges are shrinking. There is no such thing as "cost shifting" in a competitive market.

Under this proposal, there is a guaranteed, steady stream of funds available to local communities who provide indigent care. The funding expands and contracts as the number of uninsured expands and contracts.

SUMMARY

Reform of the United States health care system is less complicated than it first might appear. The building blocks of an ideal system are already in place. The Federal Government already generously subsidizes private health insurance and safety net care. What is wrong with the current system is that there are too many perverse incentives.

One could reasonably argue that government is doing more harm than good, and that a laissez faire policy is better than what is now in place. Nonetheless, if government is going to be involved in a major way in the health care system, perverse incentives should be replaced with neutral ones. At a minimum, government policy should be neutral between private insurance and the social safety net, never spending more on free care for the uninsured than it spends to encourage the purchase of private insurance. Careful application of this principle would go a long way toward creating an ideal health care system.

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PERSPECTIVE—What Is Consumer-Directed Health Care?

Comparing Patient Power With Other Decision Mechanisms

ABSTRACT: To control health care costs, someone must choose between health care and other uses of money. The value of most health care is experienced subjectively, as is the value of other goods and services. No one is in a better position to make these subjective trade-offs than patients themselves. The current system not only systematically denies patients the opportunity to make such choices, it distorts the incentives of providers in the process. Chronic patients in particular would be much better off if they could manage more of their own health care dollars and if providers were free to compete to meet their needs. [*Health Affairs* 25 (2006): w540–w543 (published online 24 October 2006; 10.1377/ hlthaff.25.w540)]

Consumer-directed health care (CDHC) is a potential solution to two perplexing problems: (1) how to choose between health care and other uses of money, and (2) how to allocate resources in an industry where normal market forces have been systematically suppressed. Unfortunately the paper by Melinda Beeuwkes Buntin and colleagues does not discuss the problems that CDHC advocates set out to solve.[1] Because they do not acknowledge that health care has to be rationed, the authors do not compare patient power with other decision mechanisms. Because they do not acknowledge that scarce resources must be allocated among unlimited wants, they do not compare price rationing with other rationing schemes. I promise to be more direct.

THE NEED TO RATION HEALTH CARE

One of the cardinal beliefs of advocates of single-payer health insurance (and one that is shared by many advocates of the health maintenance organization, or HMO, form of health care delivery) is that health care should be free at the point of consumption, regardless of willingness or ability to pay. But if health care really were free (and easily accessible), people would have at least an economic incentive to use health care until its value at the margin approaches zero. That would imply an enormous amount of waste.

Granted, the current system of third-party payment discourages many expenditures by failing to cover them (even if useful) and by erecting barriers such as waiting for care. But even the current payment system is unstainable. Christian Hagist and Laurence Kotlikoff have shown that if health care spending grows at the rate of the past 30 years, it will equal one-third of national income by mid-century, when today's college students reach retirement age.[2] If private spending on health care keeps up with public spending, the Nation will devote about two-thirds of its income to health care by 2050—roughly equal to total consumption of all goods and services today.

Patients as choosers. To avoid this disastrous scenario, someone must choose between health care and other uses of money. The question is: Who will that someone be?

Critics of CDHC are fond of pointing out that there are times when patient choice is not desirable or appropriate. They are, of course, correct. We do not want a parent to choose not to have her child vaccinated; or an at-risk expectant mother to avoid prenatal care; or a heart patient to eschew aspirin or beta blockers. The reason: There is overwhelming evidence that the social benefits of such care exceed its social costs.[3] Yet instances where we are sure that we know which alternative is best are rarer than one might suppose. At the other extreme, in thousands of cases, only the patient can make the right choice.

Take arthritic pain relief. The annual cost of brand name drugs runs about $800 more than over-the-counter (OTC) substitutes, and they are riskier (Vioxx and Bextra, for example, have been removed from the market). Is the extra cost and risk worth the marginal improvement in pain relief offered by the prescription drug? Since drugs affect different people differently, we cannot determine for someone else which is more valuable. So it is appropriate and desirable for people to make these decisions themselves—to reap the full benefits and bear the full costs of their decisions.

Mechanisms for choosing. Buntin and her colleagues define *consumer-directed health care* as high-deductible health plans. This is unfortunate.[4] Although there is no doubt that high deductibles reduce spending, the question is: Why? Patients who are liquidity-constrained might forgo care—not because it is less valuable than other uses of money, but because (living paycheck to paycheck) they might not have the cash. This is why virtually all CDHC advocates endorse individual self-insurance through a funded account.

With a properly designed health savings account (HSA), people will not spend a dollar on health care services unless they get a dollar's worth of value.[5] With a properly designed insurance plan, people will self-insure for expenses for which individual choice is appropriate and desirable.[6] The HSA design required by Federal law falls short of these ideals.[7]

The law also requires employers to make the same deposit to every employee's account—despite the fact that actual health care costs vary radically among employees. Additionally, the law virtually forces employees to use their HSAs in a way that piggybacks on the current payment system rather than fundamentally challenging it. For example, even if the patient saves money by buying an OTC drug rather than a prescription drug, his or her spending does not count toward the deductible unless the OTC drug is covered by the plan (which is typically not the case).

Despite these defects, HSAs are a small but important step in the direction of a health care system in which individuals ration their own health care, instead of having those decisions made by impersonal bureaucracies or doctors who answer to those bureaucracies.

THE NEED TO ALLOCATE RESOURCES

On average, every time Americans spend a dollar on physician services, only 10 cents is paid for out-of-pocket; the remainder is paid by a third party—an employer, insurance company, or government.[8] From a purely economic perspective, then, our incentive is to consume physician services until their value to us is only 10 cents on the dollar. Clearly, we are not rationing health care on the basis of price.

In general, the physicians time is rationed based on patients' willingness and ability to pay for care with time rather than money. Physicians, by contrast, are paid by task. This suppression of the price system has been bad for patients in a number of ways.

Lack of telephone and e-mail consultations. Whereas lawyers and other professionals routinely communicate with their clients by phone and e-mail, it is very rare for physicians to communicate that way, even for routine prescriptions.[9] Why? The short answer: They do not get paid for these types of consultations.[10] Medicare does not pay for them, nor does Medicaid or most private insurance.

The fact that patients cannot conveniently consult with physicians leads to two bad consequences. First, the unnecessary office visitors (say, patients who have a cold) expect at least a prescription in return for their investment of waiting time, and all too often the drug will be an antibiotic. Were telephone consultations possible, the physician might recommend an OTC remedy, thus avoiding the cost of waiting for the patient and the cost of degrading the effectiveness of antibiotics for society as a whole.

At the same time, rationing by waiting imposes disproportionate costs on patients who need more contact with physicians: the chronically ill. This might be one reason why so many are not getting what they most need from primary care physicians and what is most likely to prevent more costly problems later on: prescription drugs.[11] The ability to consult with doctors by phone or e-mail could be a boon to chronic care. Face-to-face meetings with physicians would be less frequent, especially if patients learned how to monitor their own conditions and manage their own care.

Lack of electronic health records. Whereas the computer is ubiquitous in our society and studies show that electronic health record (EHR) systems have the capacity to improve quality and greatly reduce medical errors, no more than one in five physicians or one in four hospitals have such systems.[12] Why are most medical records still stored on paper? Again, the short answer is this: There is no financial incentive not to do so. For the most part, we collect, manage, and distribute most medical information by means of "pen, paper, telephone, fax, and Post-It note" because doctors cannot get compensated for making an investment in computer technology.[13]

Inadequate advice about drugs and other therapies. Why do doctors so often prescribe brand name drugs and fail to tell patients about generic, therapeutic, and OTC substitutes? Why do they typically not know the price of the drugs they prescribe or the costs of alternatives? Once again, the short answer is this: They do not get paid to know these things. Knowing the current best price, knowing where the patient can obtain that price, and knowing all the prices and availabilities of all of the alternatives is demanding and time-consuming. For the doctor, it is time that is not compensated.

Inadequate patient education. Numerous studies have shown that chronic patients can often manage their own care, with lower costs and as good or better health outcomes than with traditional care. Diabetics, for example, can monitor their own glucose levels, alter their medications when needed, and reduce the number of trips to the emergency room (ER).[14] Similarly, asthmatics can monitor their peak airflows, adjust their medications, and also reduce ER visits.[15]

The problem is, to take full advantage of these opportunities, patients need training, which they rarely receive. ER doctors could save themselves and future doctors the necessity of a lot of future ER care if they take the time to educate the mother of a diabetic or asthmatic child about how to monitor and manage the child's health care. But time spent on such education is not billable.

Lack of competition for patients. One consequence of rationing by waiting is that doctors have little incentive to compete for patients the way other professionals compete for clients. Unless a primary care physician is starting a new practice or working in a rural area, his or her time is usually fully booked. As a result, neither a loss of some existing patients nor a gain of a few new patients has much effect

on the doctor's income. Loss of some existing patients, for example, would tend to reduce the average waiting time for the remaining patients. But with shorter waiting times, those patients would be encouraged to make more visits. Conversely, a gain of new patients would tend to lengthen waiting times, causing some patients to reduce their number of visits. Because time, not money, is the currency we use to pay for care, the physician doesn't benefit (very much) from patient-pleasing improvements and is not harmed (very much) by an increase in patient irritations.

RATIONING BY WAITING VERSUS RATIONING BY PRICE

Virtually all of the features of our health care system discussed above are the direct result of the way in which we pay for health care. We compensate physicians in ways that are different from the way we pay for other professional services, and those differences create problems in the medical marketplace that do not arise (at least to the same degree) in other markets. The principal payment methods, moreover, are not the natural result of free-market forces. They are instead the product of distortions created by public policies.

Would physicians practice medicine differently if they were paid differently? There is ample evidence that the answer is yes. Unlike other forms of surgery, the typical cosmetic surgery patient can (1) find a package price in advance covering all services and facilities, (2) compare prices prior to the surgery, and (3) pay a price that is lower in real terms than the price charged a decade ago for comparable procedures—despite considerable technological innovations in the interim.[16]

Ironically, many physicians who perform cosmetic surgery also perform other types of surgery. The difference in behavior is apparently related to how they are paid. A cosmetic surgery transaction has all of the characteristics of a normal market transaction in which the seller has a financial interest in how all aspects of the transaction affect the buyer. In more typical doctor-patient interactions, doctors are not paid to be concerned about all aspects of care and therefore typically ignore the effects on the patient of the cost of time, the cost of drugs, and other ancillary costs. And what is true for U.S. doctors in general is also true of doctors who practice in the government-run health systems of other developed countries.

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Chairman KENNEDY. Very good.
Ms. Davis.

STATEMENT OF KAREN DAVIS, PRESIDENT, THE COMMONWEALTH FUND, NEW YORK, NY

Ms. DAVIS. Thank you, Mr. Chairman and members of the committee, for this invitation to testify.

As you've shown, the search for effective strategies to extend health insurance coverage to all Americans and contain costs is urgent. Other countries are achieving universal coverage. They have much lower spending per capita. We're about twice what other countries spend. We spend 16 percent of GDP, they spend 8 to 10 percent, and they achieve, on the whole, the same, or better, health outcomes. By contrast, 40 percent of U.S. adults report not getting needed care in the United States because of costs. That's a rarity in other countries. U.S. patients find it much more difficult to get in to see their physician on the same day, or to receive care after regular hours. Americans are much less likely to have been with the same physician for 5 years or more, and only one in four American primary care physicians report use of electronic medical records, and that's compared with over 90 percent in countries like Denmark, the Netherlands, New Zealand, and the United Kingdom. The fragmentation of the U.S. health insurance system leads to much higher administrative costs.

The key question is how other countries achieve universal coverage and greater efficiency, while maintaining and improving the quality of care for all. There are a number of examples in my testimony, but I'd like to just illustrate with the case of Denmark.

Public satisfaction with the health system is higher in Denmark than in any other country in Europe. Denmark has universal health insurance coverage, as is true of most European countries, with no patient cost-sharing for physician and hospital services. Every Dane selects a primary care physician, who receives a monthly fee for serving as the patient's medical home, in addition to fee for services that they provide. Patients can easily obtain care on the same day if they are sick or need medical attention.

Denmark has an organized evening and weekend service. After regular hours, physicians on duty are paid for providing telephone advice, writing prescriptions by computer or electronically, or treating patients at clinics. All primary care physicians are required to have an electronic medical records system, and they do, all of the GPs, and are paid for e-mail consultations. The easy accessibility of physician advice by phone or e-mail cuts down markedly on both

physician and patient time. Physicians are supported by a nationwide health information exchange, which is a repository of electronic information on each patient's medications, tests, and prior medical history, and it costs $2 million a year for 5.3 million Danes, 40 cents a person.

There are many other examples of innovative practices that the United States might wish to investigate more closely and potentially adapt. Achieving a high-performance health care system that has high-quality, safe, effective, and accessible care for all requires a number of things that have been talked about today: extending health insurance coverage to all; supporting research and innovation to improve quality and safety and the spread of best practices; having patient-centered medical homes and organized off-hours care; public information on cost and quality; financial rewards for quality and efficiency, and information technology, as well as a health information exchange system, to pool that information; emphasis on a primary care workforce; but, most of all, it requires national leadership.

Thank you very much.

[The prepared statement of Ms. Davis follows:]

PREPARED STATEMENT OF KAREN DAVIS

EXECUTIVE SUMMARY

Thank you, Mr. Chairman and members of the committee, for this invitation to testify today on a problem of concern to all Americans: gaps in health insurance coverage and rising health care costs.

The search for effective strategies to extend health insurance coverage to more Americans and contain costs is urgent. One-third of all Americans and two-thirds of low-income Americans are uninsured or underinsured at some point during the year. Family health insurance premiums have risen 87 percent since 2000 while median family incomes have only increased by 11 percent. One-third of families now report medical bill or medical debt problems. We spend 16 percent of our Gross Domestic Product on health care, yet we fall short of reaching achievable benchmark levels of quality care.

The key question is how to achieve improved coverage and greater efficiency while maintaining or improving quality. Other countries are achieving universal coverage, much lower spending per capita, and better health outcomes. While the United States is unlikely to adopt another country's health system in all its aspects, it is instructive to review what we know about the U.S. health system compared to that of other nations, and highlight examples of high performance and innovative practices that may provide insights relative to the current U.S. challenge of simultaneously achieving better access, higher quality, and greater efficiency.

U.S. HEALTH SYSTEM PERFORMANCE LAGS BEHIND MANY OTHER INDUSTRIALIZED NATIONS

The United States spends almost $2 trillion, or $6,700 per person on health care—more than twice what other major industrialized countries spend, and spending in the United States rose faster than other countries in the last 5 years. Yet the United States is also alone among major industrialized nations in failing to provide universal health coverage. This undermines performance of the U.S. health system in multiple ways. Forty percent of United States adults report not getting needed care because of cost. And almost one-fourth of sicker adults in the United States wait 6 or more days to see a doctor, compared with one in seven or less in New Zealand, German, Australia, or the United Kingdom.

The United States also stands out for difficulty obtaining care on nights and weekends. Only 40 percent of U.S. physicians say they have an arrangement for after-hours care, compared with virtually all primary care physicians in the Netherlands.

On key health outcome measures the United States is average or worse. On mortality from conditions that are preventable or treatable with timely, effective medical care, the United States ranked 15th out of 19 countries.

And the U.S. health care system also fails to ensure accessible and coordinated care for all patients. Only 42 percent of Americans have been with the same physician for 5 years or more, compared with nearly three-fourths of patients in other countries. While patients in the United States may need to change physicians when their employers change coverage, many other countries encourage or require patients to identify a "medical home" which is their principal source of primary care, responsible for coordinating specialist care when needed.

U.S. patients are more likely to report medical errors than residents of other countries. Overall one-third of sicker adults in the United States reported such errors in 2005, compared with one-fourth in other countries. And finally, only about one-fourth of U.S. primary care physicians report use of electronic medical records—compared with 9 in 10 primary care physicians in the Netherlands, New Zealand, and the United Kingdom.

The fragmentation of the U.S. health insurance system leads to much higher administrative costs as well. In 2005, the U.S. health system spent $143 billion on administrative expenses, and in 2004, if the United States had been able to lower the share of spending devoted to insurance overhead to the same level found in the three countries with the lowest rates (France, Finland, and Japan), it would have saved $97 billion a year.

INNOVATIONS IN OTHER COUNTRIES THAT PROVIDE EXAMPLES OF HIGH PERFORMANCE

Through the Commonwealth Fund's 9-year experience conducting comparative surveys of the public and health professionals in selected countries, I'm pleased to share with the committee selected innovations that stand out as possibilities for the United States to consider—in Denmark, the Netherlands, Germany, and the United Kingdom.

Public satisfaction with the health system is higher in Denmark than any country in Europe. This is related to the emphasis Denmark places on patient-centered primary care, which is highly accessible and supported by an outstanding information system that assists primary care physicians in coordinating care. Denmark, like most European countries, has universal health insurance, with no patient cost-sharing for physician or hospital services. Every Dane selects a primary care physician who receives a monthly payment for serving as the patient's medical home, in addition to fees for services provided. Patients can easily obtain care on the same day if they are sick or need medical attention.

But what most impresses me about the Danish system is its organized "off-hours service." In every county, clinics see patients at nights and weekends. Physicians directly take calls from patients and can access computerized patient records. They can electronically prescribe medications, or ask the patient to come in to see a physician on duty. Physicians are paid for the telephone consultation, and paid a higher fee if the problem can be handled by phone. The patient's own primary care physician receives an e-mail the next day with a record of the consultation.

All primary care physicians (except a few near retirement) are required to have an electronic medical record system, and 98 percent do. Danish physicians are paid for e-mail consultations with patients. The easy accessibility of physician advice by phone or e-mail, and electronic systems for prescriptions and refills cuts down markedly on both physician time and patient time. Primary care physicians save an estimated 50 minutes a day from information systems—a return that justifies their investment in a practice information technology system.

Physicians are supported by a nationwide health information exchange, which is a repository of electronic prescriptions, lab and imaging orders and test results, specialist consult reports, and hospital discharge letters, accessible to patients, and authorized physicians and home health nurses. It now captures 87 percent of all prescription orders; 88 percent of hospital discharge letters; 98 percent of lab orders; and 60 percent of specialist referrals. Yet, its operating cost is only $2 million a year, or 40 cents per person.

Germany is a leader in national hospital quality benchmarking, with real-time quality information available on all 2,000 German hospitals with over 300 quality indicators for 26 conditions. Peers visit hospitals whose quality is substandard, and enter into a "dialogue." Typically within a few years all hospitals come up to high standards. Germany has instituted disease management programs and clinical guidelines for chronic care, with financial incentives to develop and enroll patients and be held accountable for care with early results showing positive effects on quality.

The Netherlands stands out for its leadership on transparency in reporting quality data, as well as its own approach to primary care and "after hours" care arrange-

ments. Although most Dutch primary care practices are solo practices, they support each other through a cooperative including an after hours nurse and physician call bank service. The Dutch government funds nurse practitioners based in physician practices to manage chronic disease. Under national reforms implemented in 2006, payments to Dutch doctors now blend capitation, fees for consultations, and payments for performance.

The United Kingdom General Practitioner contract in April 1, 2004 provided bonuses to primary care physicians for reaching quality targets. Far more physicians met the targets than anticipated, leading to a controversial cost over-run, but demonstrating that financial incentives do change physician behavior. The United Kingdom National Institute of Clinical Effectiveness conducts cost-effectiveness review of new drugs and technology. The United Kingdom also publishes extensive information on hospital quality and surgical results by name of hospital and surgeon.

These are just a few examples of innovative practices that the United States might wish to investigate more closely and potentially adapt. Most, however, require leadership on the part of the central government to set standards, ensure the exchange of health information, and reward high performance on quality and efficiency.

CONCLUSION

The United States has the world's costliest health system yet still fails to provide everyone with access to care—and falls far short of providing the safe, high-quality care that is possible to provide. The conclusion that there is room for improvement is inescapable. Achieving a high-performance health care system—high-quality, safe, efficient, and accessible to all—will require a major change in the U.S. system of delivering health services. Steps we can take include:

- Extending health insurance to all, in order to improve access, quality, and efficiency;
- Assessing innovations leading to high performance within the United States and internationally and adopting best practices;
- Organizing the care system to ensure coordinated and accessible care to all;
- Increasing transparency and rewarding quality and efficiency;
- Expanding the use of information technology and systems of health information exchange;
- Developing the workforce required to foster patient-centered and primary care; and
- Encouraging leadership and collaboration among public and private stakeholders dedicated to achieving a high performance health system.

These steps would take us a long way toward ensuring that the United States is a high-performing health system worthy of the 21st century. Thank you very much for the opportunity to join this panel. I look forward to learning from my fellow panelists and answering any questions.

LEARNING FROM HIGH PERFORMANCE HEALTH SYSTEMS AROUND THE GLOBE

Thank you, Mr. Chairman and members of the committee, for this invitation to testify today on a problem of concern to policymakers, employers, health care leaders, and insured and uninsured Americans alike: gaps in health insurance coverage and rising health care costs. The search for effective coverage and cost-containment strategies is of great urgency. One-third of all Americans and two-thirds of low-income Americans are uninsured at some point during the year or are underinsured.[1] Family health insurance premiums under employer plans have risen 87 percent since 2000 while median family incomes have only increased by 11 percent.[2] As a result, one-third of families now report medical bill or medical debt problems, and the problem is growing rapidly for middle class families.[3] We spend 16 percent

[1] C. Schoen, K. Davis, S.K.H. How, and S.C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457–w475; C. Schoen, M.M. Doty, S.R. Collins, and A.L. Holmgren, "Insured but Not Protected: How Many Adults Are Underinsured?" *Health Affairs* Web Exclusive (June 14, 2005):w289–w302.

[2] P. Fronstin and S.R. Collins, *The 2nd Annual EBRI/Commonwealth Fund Consumerism in Health Care Survey, 2006: Early Experience With High-Deductible and Consumer-Driven Health Plans* (New York: The Commonwealth Fund, Dec. 2006).

[3] S.R. Collins, K. Davis, M.M. Doty, J.L. Kriss, and A.L. Holmgren, *Gaps in Health Insurance: An All-American Problem* (New York, The Commonwealth Fund, Apr. 2006); S.R. Collins, J.L. Kriss, K. Davis, M.M. Doty, and A.L. Holmgren, *Squeezed: Why Rising Exposure to Health Care*

Continued

of our Gross Domestic Product on health care, yet we fall short of reaching achievable benchmark levels of quality care.[4]

Broad consensus now exists on the need for action. A recent survey of health care opinion leaders placed expanding coverage for the uninsured and enacting reforms to moderate rising health care costs at the top of a list of health care priorities for Congress.[5] Their priorities are the public's priorities as well. Ensuring that all Americans have adequate, reliable health insurance and controlling the rising cost of medical care were cited in a survey of U.S. adults last summer as the two top health care priorities for the President and Congress.[6]

The key question is how to achieve both these goals while maintaining or improving the quality of care for all. Insight is provided by contrasting the experience of the United States with that of other countries. There is now extensive evidence that other countries are achieving universal coverage, much lower spending per capita, and better health outcomes.[7] Given its history, institutions, and preferences, the United States is unlikely to adopt another country's health system in all its aspects, but it can learn from examples of practices that contribute to high performance. Today, I would like to share with the committee what we know about the U.S. health system compared to that of other countries, and highlight some examples of high performance and innovative practices in countries like Denmark, the Netherlands, and Germany, among others, that provide potential solutions to the current U.S. challenge of simultaneously achieving better access, higher quality, and greater efficiency.

This assessment of innovations leading to high performance internationally confirms and underscores the work of the Commonwealth Fund's Commission on a High Performance Health System that has identified seven keys to a high performance health system in the United States:

- Extending health insurance to all;
- Pursuing excellence in the provision of safe, effective, and efficient care;
- Organizing the care system to ensure coordinated and accessible care to all;
- Increasing transparency and rewarding quality and efficiency;
- Expanding the use of information technology and systems of health information exchange;
- Developing the workforce required to foster patient-centered and primary care; and
- Encouraging leadership and collaboration among public and private stakeholders dedicated to achieving a high performance health system.[8]

NATIONAL HEALTH EXPENDITURES AND VALUE FOR MONEY

Nothing makes it clearer that something is amiss than the contrast between health spending in the United States and health spending in other countries. The United States spends almost $2 trillion, or $6,700 per person on health care—more than twice what other major industrialized countries spend. (Figure 1)[9] Even in contrast to its substantial economy, the United States spends 16 percent of GDP on health care, while other countries spend 8 to 10 percent. Health spending in the United States rose faster than other countries in the last 5 years, while countries with high spending such as Germany and Canada moderated their growth, and

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Costs Threatens the Health and Financial Well-Being of American Families (New York: The Commonwealth Fund, Sept. 2006).

[4] K. Davis, C. Schoen, S. Guterman, T. Shih, S.C. Schoenbaum, and I. Weinbaum, *Slowing the Growth of U.S. Health Care Expenditures: What Are the Options?* (New York: The Commonwealth Fund, Jan. 2007).

[5] A.L. Holmgren, K. Davis, S. Guterman, and B. Scholl, *Health Care Opinion Leaders' Views on Priorities for the New Congress* (New York: The Commonwealth Fund, Jan. 2007).

[6] C. Schoen, S.K.H. How, I. Weinbaum, J.E. Craig, Jr., and K. Davis, *Public Views on Shaping the Future of the U.S. Health System* (New York: The Commonwealth Fund, Aug. 2006)

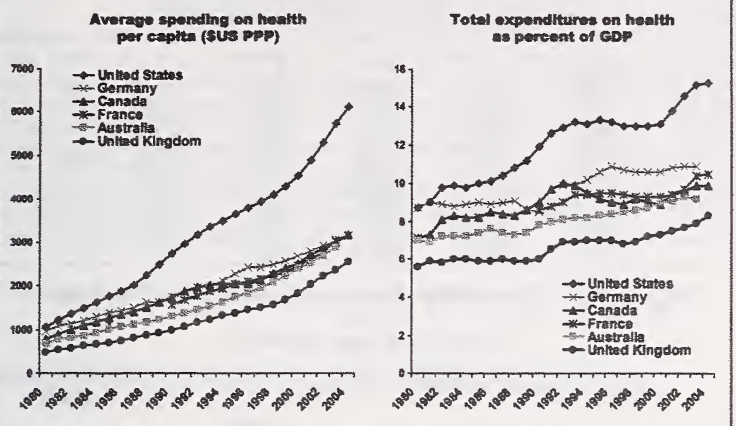
[7] C. Schoen, R. Osborn, P.T. Huynh, M.M. Doty, J. Peugh, and K. Zapert, "On the Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries," *Health Affairs* Web Exclusive (Nov. 2, 2006):w555–w571; C. Schoen, R. Osborn, P.T. Huynh, M. Doty, K. Zapert, J. Peugh, and K. Davis, "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive (Nov. 3, 2005):w509–w525; P.S. Hussey, G.F. Anderson, R. Osborn et al., "How Does the Quality of Care Compare in Five Countries?" *Health Affairs*, May/June 2004 23(3):89–99.

[8] The Commonwealth Fund Commission on a High Performance Health System, *Framework for a High Performance Health System for the United States* (New York: The Commonwealth Fund, Aug. 2006).

[9] A. Catlin, C. Cowan, S. Heffler, B. Washington, and the National Health Expenditure Accounts Team, "National Health Spending in 2005: The Slowdown Continues," *Health Affairs* Jan./Feb. 2007 26(1):142–153.

countries with low spending such as the United Kingdom increased outlays as a matter of deliberate public policy.

Figure 1. International Comparison of Spending on Health, 1980–2004



Data: OECD Health Data 2005 and 2006.

Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

All countries face rising costs from technological change, higher prices of pharmaceutical products, and aging of the population. In fact, the population in most European countries already has the age distribution that the United States will experience in 20 years. Nor is the difference in spending attributable to rationing care. In fact, the United States has lower rates of hospitalization and shorter hospital stays than most other countries.[10] One difference is that the United States tends to pay higher prices for prescription drugs; in other countries governments typically negotiate on behalf of all residents to achieve lower prices.[11]

The United States is alone among major industrialized nations in other respects. Over half of health care spending is paid for privately, compared with about one-fourth or less in other countries. Ironically, because the United States is so expensive, the government—while it accounts for only 45 percent of all health care spending—spends as much as a percent of GDP on health care as do other countries with publicly financed health systems.[12]

Another striking difference is that the United States has fewer physicians per capita than other countries, and many more of our physicians are specialists.[13] Research both within the United States and across countries has shown that health care spending is higher and health outcomes worse when there is a lower ratio of primary care to specialist physicians.[14] In the United States, patients face a more fragmented health care system, are cared for by different physicians for different conditions, have poorer care coordination, and take more medications, which con-

[10] B. Frogner and G. Anderson, *Multinational Comparisons of Health Systems Data, 2005* (New York: The Commonwealth Fund, Apr. 2006).

[11] G.F. Anderson, D.G. Shea, P.S. Hussey et al., "Doughnut Holes and Price Controls," *Health Affairs* Web Exclusive (July 21, 2004):W4-396–W4-404; G. Anderson, U.E. Reinhardt, P.S. Hussey et al., and V. Petrosyan, "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* May/June 2003 22(3):89–105.

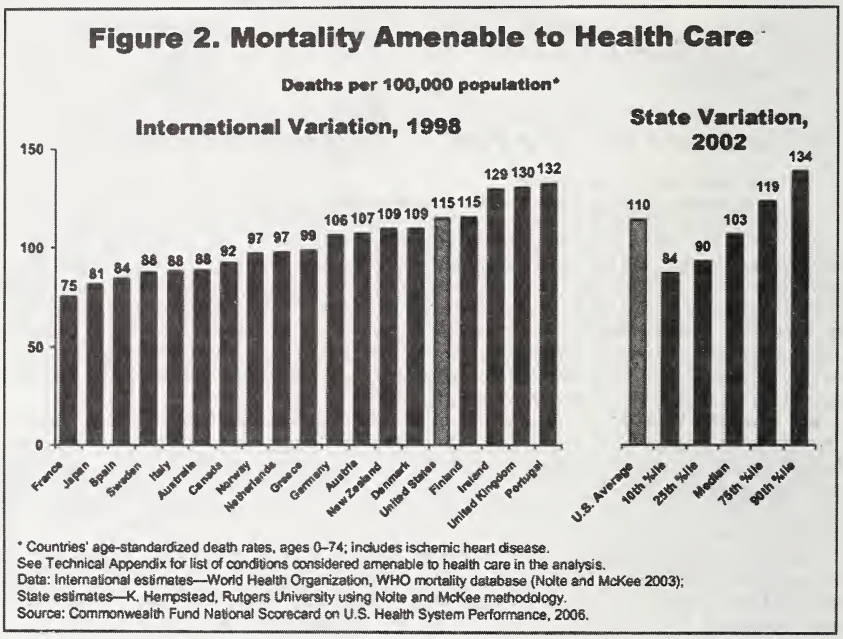
[12] B. Frogner and G. Anderson, *Multinational Comparisons of Health Systems Data*, 2005 (New York, NY: The Commonwealth Fund, Apr. 2006).

[13] G.F. Anderson, B.K. Frogner, R.A. Johns, and U.E. Reinhardt, "Health Care Spending and Use of Information Technology in OECD Countries," *Health Affairs* May/June 2006 25(3):819–831.

[14] J.S. Skinner, D.O. Staiger, and E.S. Fisher, "Is Technological Change in Medicine Always Worth It? The Case of Acute Myocardial Infarction," *Health Affairs* Web Exclusive (Feb. 7, 2006):w34–w47; B. Starfield, L. Shi, and J. Macinko, "Contribution of Primary Care to Health Systems and Health," *The Milbank Quarterly*, 2005 83(3):457–502.

tribute to higher rates of medical errors.[15] More things can and do go wrong when care is provided by multiple parties. In fact in 2006, 42 percent of U.S. adults reported one of four experiences in the prior 2 years: their physicians ordered a test that had already been done; their physician failed to provide important medical information or test results to other doctors or nurses involved in their care; they incurred a medical, surgical, medication, or lab test error; or their physician recommended care or treatment that in their view was unnecessary.[16]

The bottom line is that the United States is not receiving value commensurate to the resources it commits to health care. Many Americans would gladly pay more for health care if it meant longer lives, improved functioning, or better quality of life. Yet, on key health outcome measures the United States fares average or worse. For example, on mortality from conditions "amenable to health care"—a measure of death rates before age 75 from diseases and conditions that are preventable or treatable with timely, effective medical care, the United States ranked 15th out of 19 countries, with a death rate 30 percent higher than France, Japan, and Spain. (Figure 2) If the U.S. performance were comparable to the best 3 countries or even the best 5 States within the United States, it could save almost 90,000 lives a year.



The Commonwealth Fund supported an international working group on quality indicators, an effort that is now being continued and extended by the Organization of Economic Cooperation and Development. On most measures, the United States was neither the best nor the worst on clinical quality outcomes. It had the best outcome of five countries on 5-year relative survival rates for breast cancer (Figure 3), but the worst outcome on 5-year relative survival rates for kidney transplants.[17] (Figure 4) For the resources it commits to health care, it should be achieving much better results.

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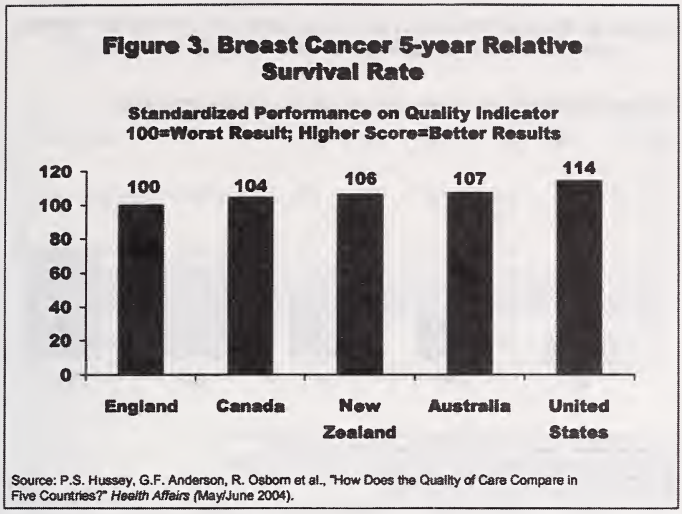
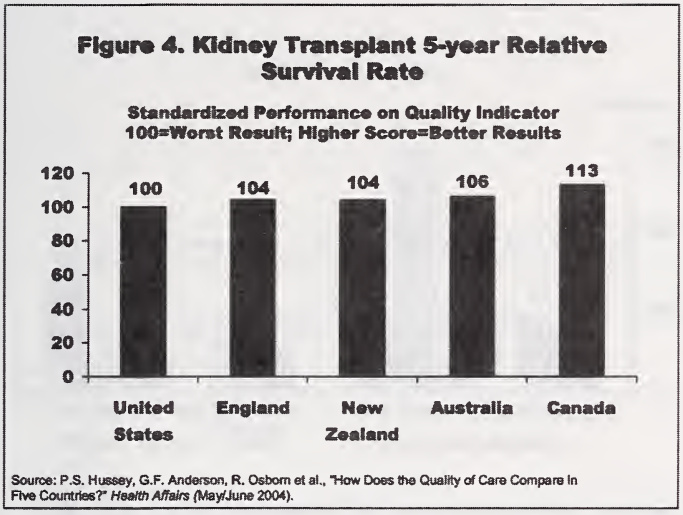
[15] C. Schoen, R. Osborn, P.T. Huynh, M. Doty, K. Zapert, J. Peugh, and K. Davis, "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive (Nov. 3, 2005):w509–w525.

[16] C. Schoen, S.K.H. How, I. Weinbaum, J.E. Craig, Jr., and K. Davis, *Public Views on Shaping the Future of the U.S. Health System* (New York: The Commonwealth Fund, Aug. 2006).

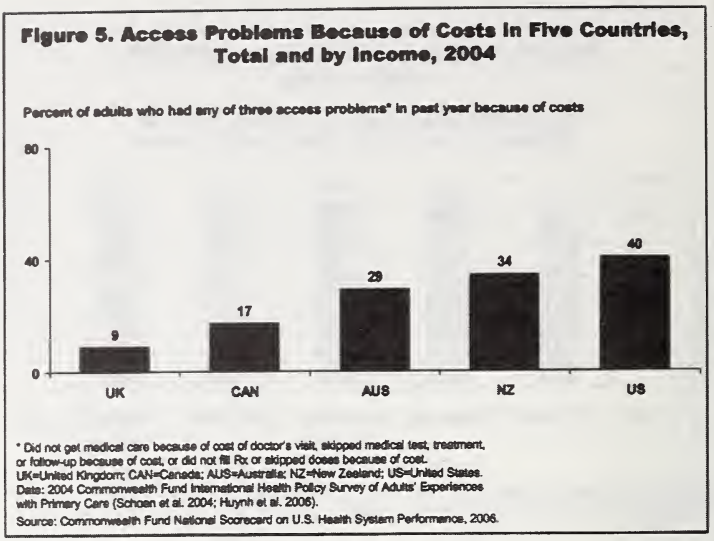
[17] P.S. Hussey, G.F. Anderson, R. Osborn, C. Feek, V. McLaughlin, J. Millar, and A. Epstein, "How Does the Quality of Care Compare in Five Countries?" *Health Affairs*, May/June 2004 23(3):89–99.

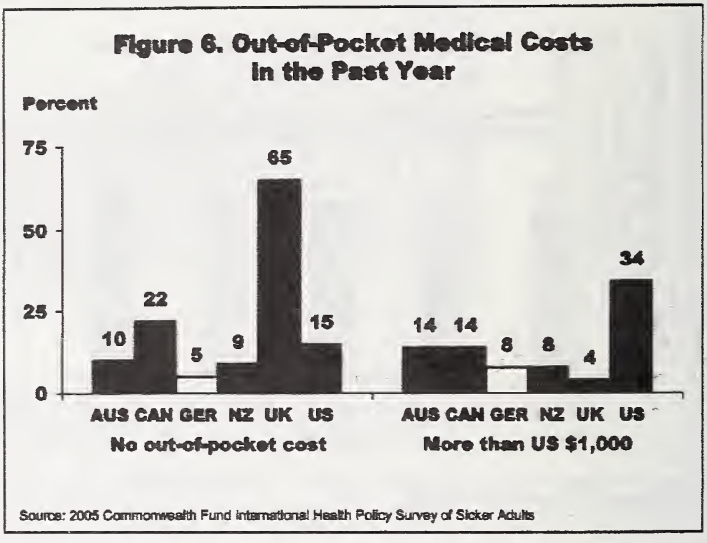




ACCESS TO CARE

The United States is also alone among major industrialized nations in failing to provide universal health coverage. This undermines performance of the U.S. health system in multiple ways, but the most troubling is the difficulty Americans face in obtaining access to needed care. (Figure 5) Forty percent of U.S. adults report one of three access problems because of costs: not getting needed care because of cost of a doctor's visit, skipping medical test, treatment, or followup because of costs, or not filling prescription or skipping doses because of cost. Further, Americans pay far more out-of-pocket for health care expenses and are more subject to financial burdens as a result of either no health insurance or inadequate health insurance. (Figure 6)





But aside from the evident failure of the U.S. health system to guarantee financial access to care, the organization of care in the United States also fails to ensure accessible and coordinated care for all patients. In fact the United States stands out for patients who report either having no regular doctor or having been with their physician for a short period of time. (Figure 7) Only 42 percent of Americans have been with the same physician for 5 years or more, compared with over half to three-fourths of patients in other countries. Managed care plans with restricted networks exacerbate poor continuity of care, as patients may need to change physicians when their employers change coverage. By contrast, many other countries encourage or require patients to identify a "medical home" which is their principal source of primary care responsible for coordinating specialist care when needed.

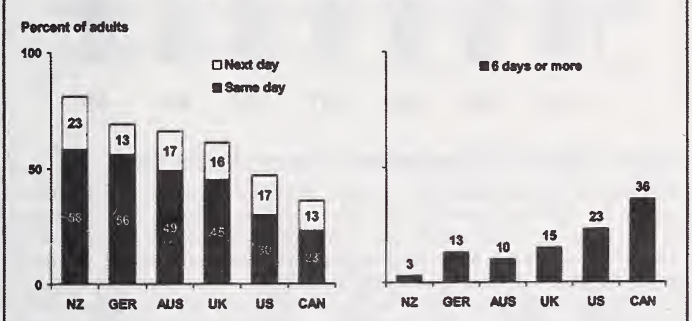
Figure 7. Length of Time with Regular Doctor

Percent:	AUS	CAN	GER	NZ	UK	US
Has regular doctor	92	92	97	94	96	84
Less than 2 years	16	12	6	19	14	17
5 years or more	56	60	76	57	66	42
No regular doctor	8	8	3	6	4	16

Source: 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults

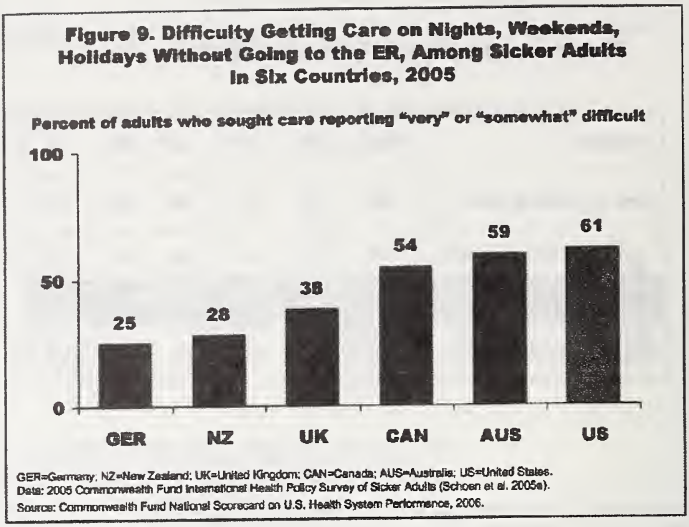
These differences in care arrangements and the relative undersupply of primary care physicians contribute to more Americans reporting an inability to get care when sick or needing medical attention—whether in the doctor's office during the day or on nights and weekends. Almost one-fourth of sicker adults in the United States and one-third of Canadian adults wait 6 or more days to get in to see a doctor when sick or need medical attention, compared with only one in seven or less in New Zealand, Germany, Australia, and the United Kingdom. (Figure 8) The United States has short waiting times for elective surgery such as hip replacements or cataract operations—but quick access to primary care is rarer in the United States.

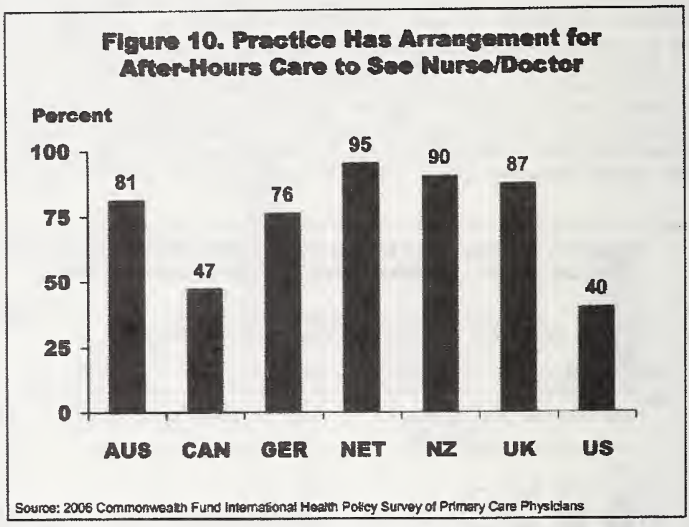
Figure 8. Waiting Time to See Doctor When Sick or Need Medical Attention, Sicker Adults in Six Countries, 2005



NZ=New Zealand; GER=Germany; AUS=Australia; UK=United Kingdom; US=United States; CAN=Canada.
Data: 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults (Schoen et al. 2005a).
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006.

The United States also stands out for difficulty obtaining care on nights and weekends. Three in five Americans report that it is difficult to obtain care off-hours, compared to one in four in Germany and New Zealand. (Figure 9) In a recent survey of primary care physicians, only 40 percent of U.S. physicians say they have an arrangement for after-hours care, compared with virtually all primary care physicians in the Netherlands. (Figure 10)





These differences in accessibility of basic primary care are a reflection of policy decisions made by different countries.[18] Most fundamentally, of course, other countries make primary care financially and physically accessible to their residents. In contrast, the United States puts substantial financial barriers to primary care including larger numbers of uninsured and significant deductibles that pose financial barriers to primary care even for the insured. Other countries provide relatively higher payments to primary care physicians, and support physician practices in organizing after hours care. These policies increase the attractiveness of primary care practice.

[18] C. Schoen, R. Osborn, P.T. Huynh, M. Doty, K. Zapert, J. Peugh, and K. Davis, "Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems in Six Countries," *Health Affairs* Web Exclusive (Nov. 3, 2005):w509–w525; C. Schoen, R. Osborn, P.T. Huynh, M. Doty, J. Peugh, and K. Zapert, "On the Front Lines of Care: Primary Care Doctors' Office Systems, Experiences, and Views in Seven Countries," *Health Affairs* Web Exclusive (Nov. 2, 2006):w555–w571.

QUALITY OF CARE

The United States faces a major increase in chronic conditions as its population ages. Sicker adults with multiple chronic conditions are particularly at risk for poor quality or uncoordinated care. Coordination of information across sites of care is essential for safe, effective, and efficient care. Measured by patients saying that test results or medical records were not available at the time of appointments or that physicians duplicated tests, one-third of U.S. patients experience breakdowns in coordination, compared with about one-fifth in other countries. (Figure 11)

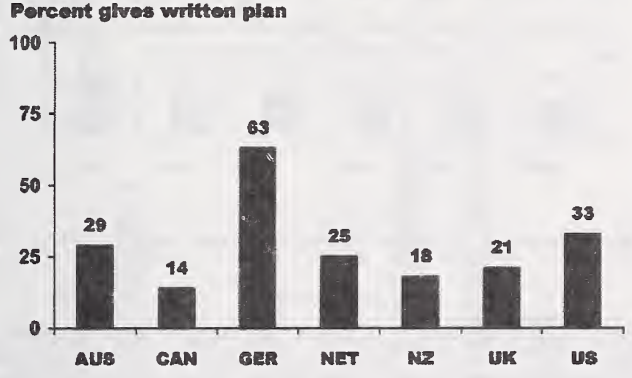
Figure 11. Patients Report Problems with Care Coordination

Percent saying in the past 2 years:	AUS	CAN	GER	NZ	UK	US
Test results or records not available at time of appointment	12	19	11	16	16	23
Duplicate tests: doctor ordered test that had already been done	11	10	20	9	6	18
Percent who experienced either coordination problem	19	24	26	21	19	33

Source: 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults

Improving the management of patients with chronic disease is key to effective control and prevention of complications. One-third of primary care physicians in the United States report routinely giving patients a care plan to manage their chronic diseases at home compared with almost two-thirds in Germany. (Figure 12)

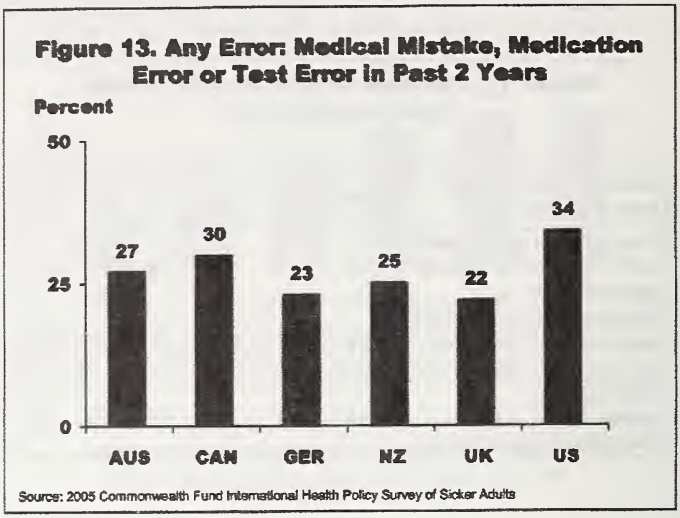
Figure 12. Doctor Routinely Gives Patients with Chronic Diseases Plan to Manage Care at Home

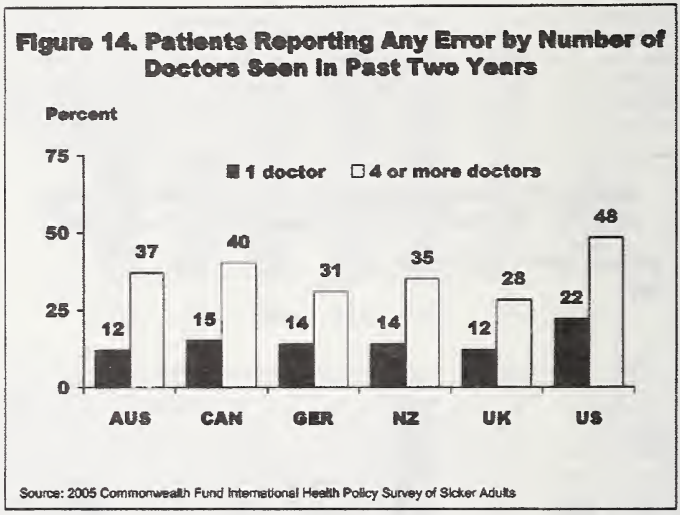


Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians

Patient safety has received heightened attention in the United States in the last 5 years. Despite this U.S. patients are more likely to report experiences of medical errors than residents of other countries—including medical or medication errors,

hospital acquired infections, or incorrect lab or diagnostic tests or delay in communicating abnormal results to patients. Overall one-third of sicker adults in the United States reported such errors in 2005, compared with one-fourth in other countries. (Figure 13) The frequency of errors was strongly associated with the number of doctors involved in a patient's care—with almost half of U.S. sicker adults seeing four or more physicians reporting such errors. (Figure 14)



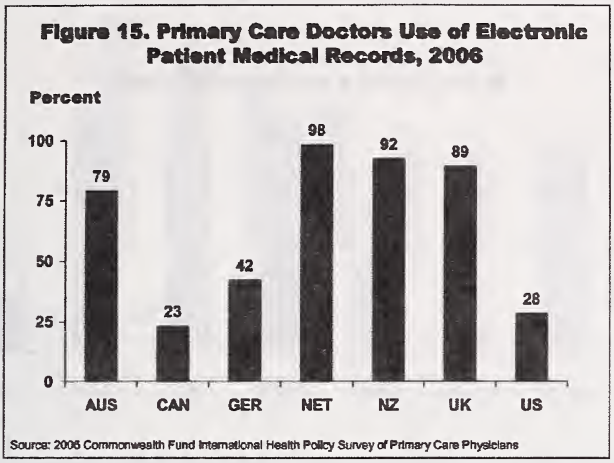


EFFICIENCY

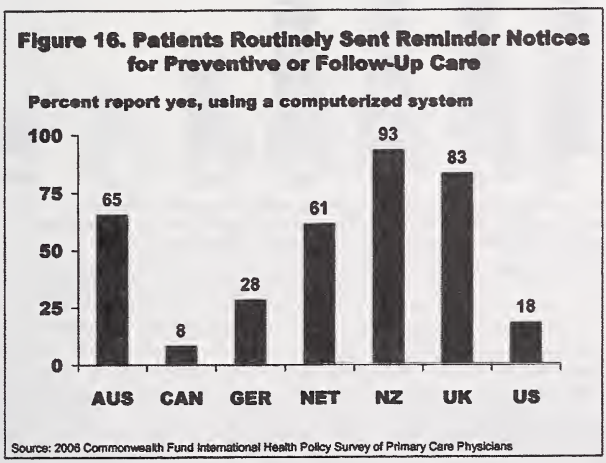
U.S. physicians are highly trained, and U.S. hospitals are well-equipped compared with hospitals in other countries.[19] Some of the waste and missed opportunities to provide high quality, safe care may be attributable to more limited adoption of information technology in the United States. About one-fourth of U.S. primary care phy-

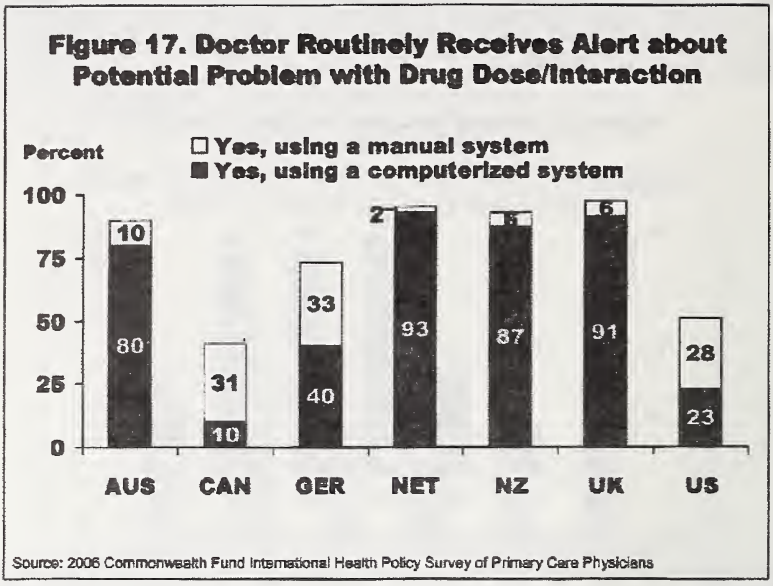
[19] A.M.J. Audet, M.M. Doty, J. Shamasdin, and S.C. Schoenbaum, *Physicians' Views on Quality of Care: Findings from The Commonwealth Fund National Survey of Physicians and Quality of Care* (New York: The Commonwealth Fund, May 2005).

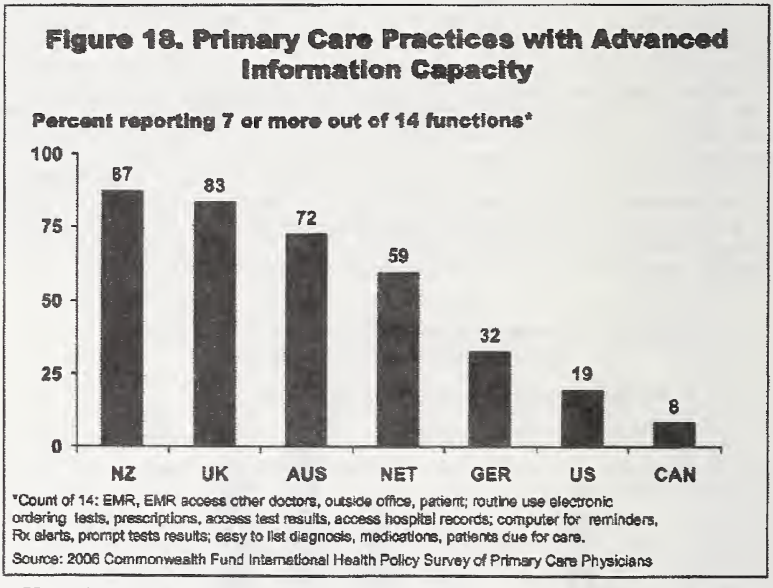
sicians report use of electronic medical records—compared with over 9 in 10 primary care physicians in the Netherlands, New Zealand, and the United Kingdom, often obtained with financial support from government either directly or through reimbursement incentives. (Figure 15)



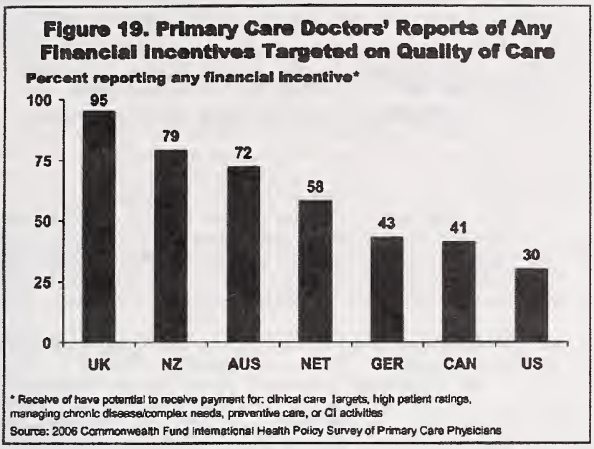
Primary care physicians in other countries not only have basic electronic medical records but an array of functionality, often facilitated by governmental arranged systems of information exchange. Less than one-fifth of U.S. primary care physicians routinely send reminder notices to patients about preventive or followup care, compared with over 9 in 10 in New Zealand. (Figure 16) Nine in ten primary care physicians in the Netherlands, New Zealand, and the United Kingdom receive alerts about potential problems with prescription drug dosage or interaction, compared with one-fourth who receive such notices in the United States through computerized systems. (Figure 17) When assessed against 14 different functions of advanced information capacity (EMR, EMR access to other doctors, access outside office, access by patient; routine use electronic ordering tests, electronic prescriptions, electronic access to test results, electronic access to hospital records; computerized reminders; Rx alerts; prompt tests results; easy to list diagnosis, medications, patients due for care), one in five U.S. primary care physicians reported having at least 7 out of the 14 functions compared to 9 in 10 physicians in New Zealand (Figure 18).





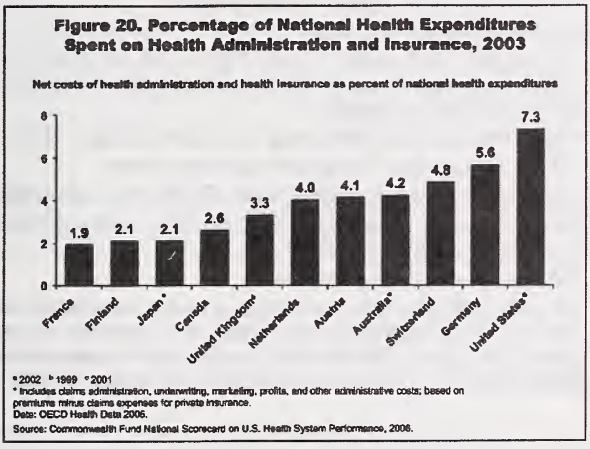


The United States relies on market incentives to shape its health care system, yet other countries are more advanced in providing financial incentives to physicians targeted on quality of care. Only 30 percent of U.S. primary care physicians report having the potential to receive financial incentives targeted on quality of care, including potential to receive payment for: clinical care targets, high patient ratings, managing chronic disease/complex needs, preventive care, or quality improvement activities. (Figure 19) By contrast nearly all primary care physicians in the United Kingdom and over 70 percent in Australia and New Zealand report such incentives.



The reliance on private insurance and the fragmentation of the U.S. health insurance system—with people moving in and out of coverage and in and out of plans, and changing their usual source of care—all contribute to high administrative costs for insurers and for health care providers.[20] In 2005, the U.S. health system spent $143 billion on administrative expenses, not including administrative expenses incurred by health care providers.[21]

The United States with its mixed public-private system of financing devotes a much higher share of health spending to administration. The United States spends 7.3 percent of total health expenditures on insurance administrative expense.[22] (Figure 20) In 2004, if the United States had been able to lower the share of health care spending devoted to insurance overhead to the same level found in the three countries with the lowest rates (France, Finland, and Japan), it would have saved $97 billion a year. If the United States had spent what countries with mixed public-private insurance systems, such as Germany and Switzerland, spend on insurance administrative costs, it could have saved $32 to $46 billion a year.



[20] K. Davis, *Time for Change: The Hidden Costs of a Fragmented Health Insurance System.* Invited Testimony, Senate Special Committee on Aging, March 10, 2003.

[21] A. Catlin, C. Cowan, S. Heffler, B. Washington, and the National Health Expenditure Accounts Team, "National Health Spending in 2005: The Slowdown Continues," *Health Affairs* Jan./Feb. 2007 26(1):142–153.

[22] C. Schoen, K. Davis, S.K.H. How, and S.C. Schoenbaum, "U.S. Health System Performance: A National Scorecard," *Health Affairs* Web Exclusive (Sept. 20, 2006):w457–w47.

INNOVATIONS IN OTHER COUNTRIES THAT PROVIDE EXAMPLES OF HIGH PERFORMANCE

The key question is how the United States might achieve improved coverage and greater efficiency while maintaining or improving the quality of care for all. Given its history, institutions, and preferences, the United States is unlikely to adopt another country's health system in all its aspects, but it can learn from examples of practices that contribute to high performance. Through the Commonwealth Fund's 9-year experience conducting comparative surveys of the public and health professionals in selected countries and sponsoring annual symposia for top government officials and experts focused on innovations, numerous examples of innovative practices and high health system performance stand out. I have also had the opportunity of serving on a team of economists critiquing the Danish health system charged with preparing a report for the Danish parliament.[23] From this experience, I'm pleased to share with the committee selected innovations that stand out as possibilities for the United States to consider, highlighting examples of high performance and innovative practices in Denmark, the Netherlands, Germany, and the United Kingdom.

Let me begin with Denmark which I visited again last October. Public satisfaction with the health system is higher in Denmark than any country in Europe.[24] In my view this is related to the emphasis Denmark places on patient-centered primary care, which is highly accessible and has an outstanding information system that assists primary care physicians in coordinating care. (Figure 21) Denmark, like most European countries, has a universal health insurance system with no patient cost-sharing for physician or hospital services. Every Dane selects a primary care physician who receives a monthly payment per patient for serving as the patient's medical home, in addition to fees for services provided. Incomes of primary care physicians are slightly higher than those of specialists, who are salaried and employed by hospitals. Primary care physicians own their own practices, which are open from 8 a.m. to 4 p.m., and patients can easily obtain care on the same day if they are sick or need medical attention.

Figure 21. Denmark Leads the Way in Patient-centered Primary Care

- **Blended primary care payment system**
  - **Fee for service**
  - **Medical home monthly fee per patient**
- **Organized off-hours service**
  - **Physicians staff phone banks nights and weekends with computerized access to patient information; paid for telephone consultations**
  - **Physicians staff evening and weekend clinics, and**
  - **Off-hours service physicians do home visits**
- **Health information technology and information exchange**
  - **98% of primary care physicians totally electronic health records and e-prescribing**
  - **Paid for e-mail with patients**
  - **All prescriptions, lab and imaging tests, specialist consult reports, hospital discharge letters flow through a single electronic portal (MedComm – a nonprofit organization) accessible to patients, physicians, and home health nurses**

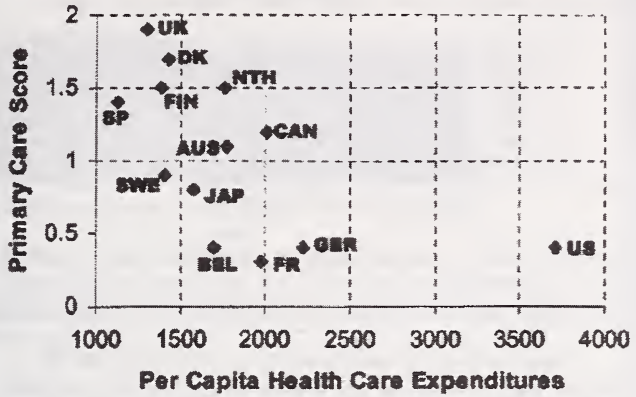
This system of primary care contributes to highly accessible basic and preventive care, and lower total health care expenditures. Denmark is rated as one of the best countries on primary care as measured by high levels of first contact accessibility,

[23] K. Davis, "The Danish Health System Through an American Lens," *Health Policy*, Jan. 2002 59(2):119–132.

[24] E. Mossialos, "Citizens Views on Health Care Systems in the 15 Member States of the European Union," *Health Economics* 1997 6:109–16.

patient-focused care over time, a comprehensive package of services, and coordination of services when services have to be provided elsewhere.[25] (Figure 22)

Figure 22. Primary Care Score vs. Health Care Expenditures, 1997



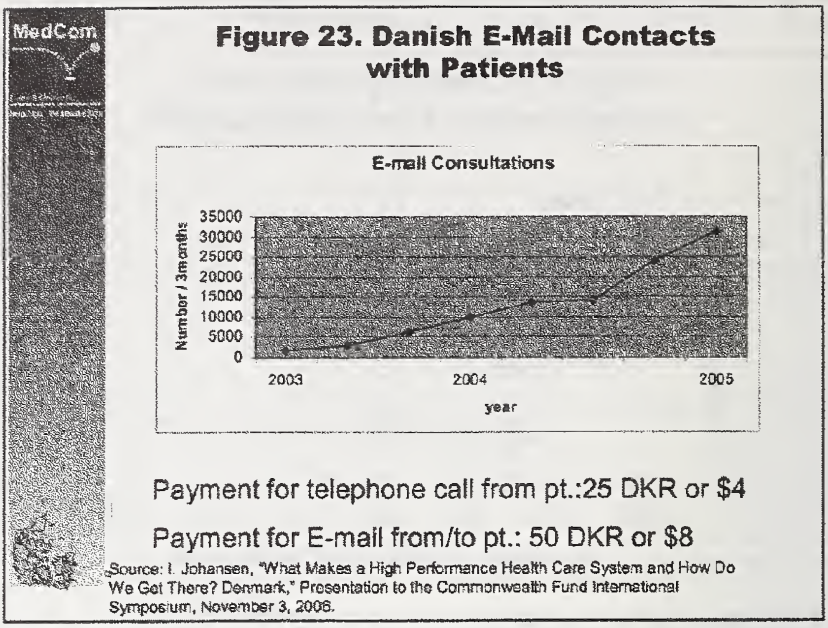
Source: B. Starfield, "Why More Primary Care: Better Outcomes, Lower Costs, Greater Equity," Presentation to the Primary Care Roundtable: Strengthening Adult Primary Care: Models and Policy Options, October 3, 2006. According to Starfield, good primary care is defined as high levels of first contact accessibility, patient-focused care over time, a comprehensive package of services, and coordination of services when services have to be provided elsewhere.

But what most impresses me about the Danish system is its organized "off-hours service." In every county, clinics see patients at nights and weekends. Physicians sit at phone banks in the "back office" of the clinic and directly take any calls from patients. They sit in front of computer terminals and can access computerized patient records. After listening to a patient's complaint, they can electronically prescribe medications, or ask the patient to come in to see a physician on duty. Physicians are paid for the telephone consultation, and paid a higher fee if the problem can be handled by phone. The patient's own primary care physician receives an e-mail the next day with a record of the consultation.

All primary care physicians (except a few near retirement) are required to have an electronic medical record system, and 98 percent do. Danish physicians are now paid about $8 for e-mail consultations with patients, a service that is growing rapidly. (Figure 23) The easy accessibility of physician advice by phone or e-mail, and electronic systems for prescriptions and refills cuts down markedly on both physician time and patient time. Primary care physicians save an estimated 50 minutes a day from information systems that simplify their tasks, a return that easily justifies their investment in a practice information technology system.[26]

[25] B. Starfield, "Why More Primary Care: Better Outcomes, Lower Costs, Greater Equity," Presentation to the Primary Care Roundtable: Strengthening Adult Primary Care: Models and Policy Options, October 3, 2006.

[26] I. Johansen, "What Makes a High Performance Health Care System and How Do We Get There? Denmark," Presentation to the Commonwealth Fund International Symposium, November 3, 2006.



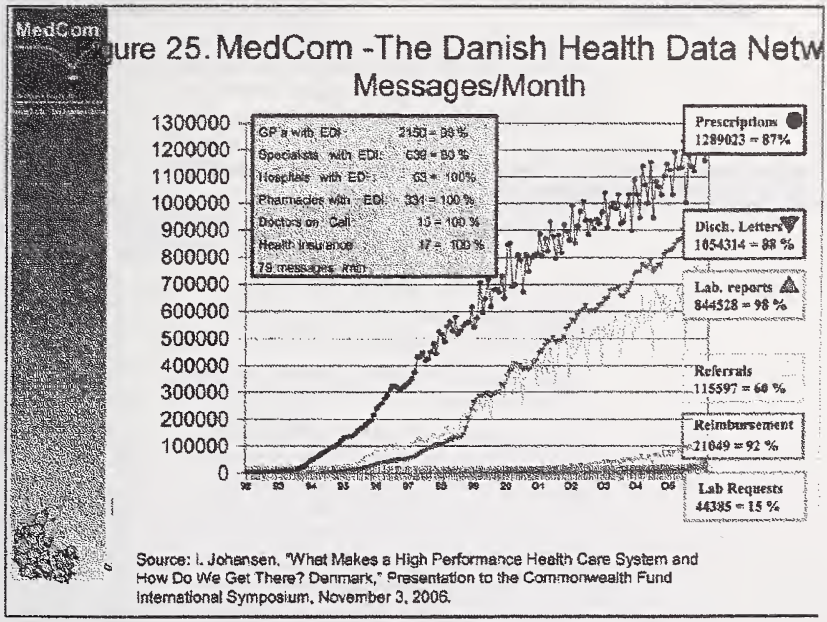
Physicians, whether seeing patients through the off-hours service or during regular hours, are supported by a nationwide health information exchange, maintained by a nonprofit organization MedComm. An assessment of information systems in 10 countries ranks Denmark at the top, and concludes that countries with a single unifying organization setting standards and responsible for serving as an information repository have the highest rates of information system functionality.[27] (Figure 24) MedComm is a repository of electronic prescriptions, lab and imaging orders and test results, specialist consult reports, and hospital discharge letters, accessible to patients, and authorized physicians and home health nurses. It now captures 87 percent of all prescription orders; 88 percent of hospital discharge letters; 98 percent of lab orders; and 60 percent of specialist referrals. (Figure 25) Yet, its operating cost is only $2 million a year for a population of 5.3 million Danes, or 40 cents a person a year.

[27] D. Protti, "A Comparison of Information Technology in General Practice in Ten Countries," Presentation to the Commonwealth Fund International Symposium, November 3, 2006.

Figure 24. Countries with a Single Unifying Organization Have Higher Rates of HIT

- **Denmark**
  - **nonprofit organization, arms length from government**
- **New Zealand**
  - **a private company**
- **Scotland**
  - **the department of health**
- ***The lack of a unifying organization is seen to be a limiting factor in a number of countries***
- **Culture and tradition; standards (e.g. communications); structured data (e.g. Read codes in England & Scotland, ICPC in Norway); and size may also be contributing factors**

Source: D. Protti, "A Comparison of Information Technology in General Practice in Ten Countries," Presentation to the Commonwealth Fund International Symposium, November 3, 2006.



Source: I. Johansen, "What Makes a High Performance Health Care System and How Do We Get There? Denmark," Presentation to the Commonwealth Fund International Symposium, November 3, 2006.

But Denmark is not the only country with cutting-edge innovations to improve the quality, accessibility, and efficiency of health care. Germany is a leader in national hospital quality benchmarking, with real-time quality information on all 2,000 German hospitals with over 300 quality indicators for 26 conditions. (Figure 26) Peers visit hospitals whose quality is substandard, and enter into a "dialogue" about why that is the case. Typically within a few years all hospitals come up to high standards. (Figure 27) Germany has instituted disease management programs and clinical guidelines for chronic care, with financial incentives from insurance funds to develop and enroll patients and be held accountable for care with initial results showing positive effects on quality.[28] (Figure 28) Germany is also experimenting with an all-inclusive global fee for payment of care of cancer patients in Cologne. (Figure 29)

Figure 26. National Quality Benchmarking in Germany

Size of the project:

- 2,000 German Hospitals (> 98%)
- 5,000 medical departments
- 3 Million cases in 2005
- 20% of all hospital cases in Germany
- 300 Quality indicators in 26 areas of care
- 800 experts involved (national and regional)

Ideas and goals:

→ define standards (evidence based, public)
→ define levels of acceptance
→ document processes, risks and results
→ present variation
→ start structured dialog
→ improve and check

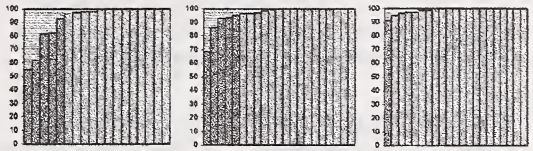
Source: Christof Veit, "The Structured Dialog: National Quality Benchmarking in Germany," Presentation at AcademyHealth Annual Research Meeting, June 2006.

[28] Michael Hallek, "Typical problems and recent reform strategies in German health care—with emphasis on the treatment of cancer," Presentation to the Commonwealth Fund International Symposium, November 2, 2006.

Figure 27. Improvement:

Hamburg: Antibiotic Prophylaxes in Hip-Replacement.

2003: 95,6% ⇒ 2004: 98,5% ⇒ 2005: 99,3%



Source: Christof Veit, "The Structured Dialog: National Quality Benchmarking in Germany," Presentation at AcademyHealth Annual Research Meeting, June 2006.

Figure 28. Disease Management Programs for Chronic Diseases in Germany

- **Conditions:**
  - **Diabetes type I and II**
  - **COPD**
  - **CHD**
  - **Breast cancer**
- **Specific regulations for care targets, drugs, quality management and documentation**
- **1.6 million enrolled patients (August 2006)**
- **Preliminary data show positive effects on quality**
- **Cost reductions unlikely**

Source: Michael Hallek, "Typical problems and recent reform strategies in German health care - with emphasis on the treatment of cancer," Presentation to the Commonwealth Fund International Symposium, November 2, 2006.

Figure 29. German Global Payment for Integrated Oncology: Key Elements

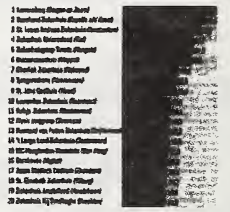
- **Treatment according to evidence-based guidelines**
- **Detailed treatment pathways and standard operating procedures (SOPs)**
  - **Define multi-disciplinary cooperation**
  - **Assign responsibilities between hospital and office-based sectors**
  - **Avoid inconsistent or redundant medical procedures**
- **New cancer-specific quality indicators**
- **Innovative financing (1-year package, global fee)**
  - **Stage-adapted global fees for 12 months from diagnosis**
  - **Fees include diagnostics, surgery, radiotherapy, chemotherapy, follow up and palliative care**
  - **Additional payments for outliers (example: early relapse)**
  - **Remuneration of office-based physicians by the oncology center**

Source: Michael Hallek, "Typical Problems and Recent Reform Strategies in German Health Care - With Emphasis on the Treatment of Cancer," Presentation to the Commonwealth Fund International Symposium, November 2, 2006.

The Netherlands also stands out for its leadership on transparency in reporting quality data, (Figure 30) as well as its own approach to primary care and "after hours" care arrangements. (Figure 31) Although most Dutch primary care practices are solo practices, they support each other through a cooperative including an after hours nurse and physician call bank service. The Dutch government funds nurse practitioners based in physician practices to manage chronic diseases. Under national reforms implemented in 2006, payments to Dutch doctors now blend capitation, fees for consultations, and payments for performance.

Figure 30. Improve Quality Transparency: The Netherlands

- **Collect comparative data: (quality indicators)**
- **Inspectorate examines care providers with different quality indicators**
- **Make quality differences visible through the Internet**



Source: Hans Hoogervorst, Minister of Health, Netherlands, "A Vision for Health Care in the 21st Century," Presentation to the Commonwealth Fund International Symposium, November 2, 2006.

Figure 31. Primary Care Organization in Netherlands

- **After hours care arrangements**
  - **Nurse and physician call banks**
- **Most are solo practices yet organized to support each other with nurse and doctor cooperative**
- **Integrated electronic medical records**
- **Widespread use of registries**

Source: R. Grol, P. Giesen, and C. van Uden, "After-Hours Care in The United Kingdom, Denmark, and the Netherlands: New Models," *Health Affairs*, November/December 2006 25(6): 1733-1737.

The United Kingdom General Practitioner contract in April 1, 2004 provided bonuses to primary care physicians for reaching quality targets. (Figure 32) Far more physicians met the targets than anticipated, leading to a controversial cost over-run, but amply demonstrating that financial incentives do change physician behavior.[29] The United Kingdom National Institute of Clinical Effectiveness conducts cost-effectiveness review of new drugs and technology. (Figure 33) The United Kingdom also publishes extensive information on hospital quality and surgical results by name of hospital and surgeon. (Figures 34 and 35)

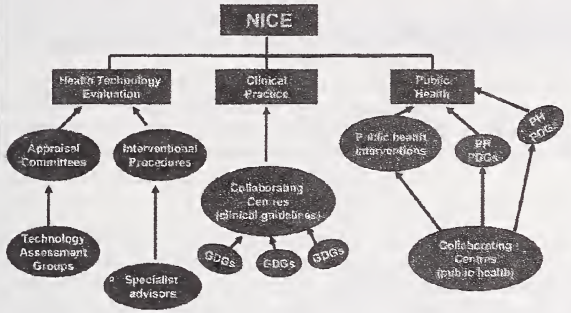
[29] T. Doran, C. Fullwood, H. Gravelle, D. Reeves, E. Kontopantelis, U. Hiroeh, and M. Roland, "Pay-for-Performance Programs in Family Practices in the United Kingdom," *New England Journal of Medicine*, 2006 355(4):375–384.

Figure 32. UK: First Year Performance

- **Practice by practice results for the Quality and Outcome Framework for England were published on August 31, 2005**
- **Average score for practices in England in the first year was 959 out of a possible 1050. The maximum score of 1,050 points was achieved by 222 practices (2.6%)**
- **8,486 practices in England took part, covering 99.5% of NHS registered patients**
- **Some of higher performance may have been improved documentation**

Source: http://www.ic.nhs.uk/services/qof/data/index_html

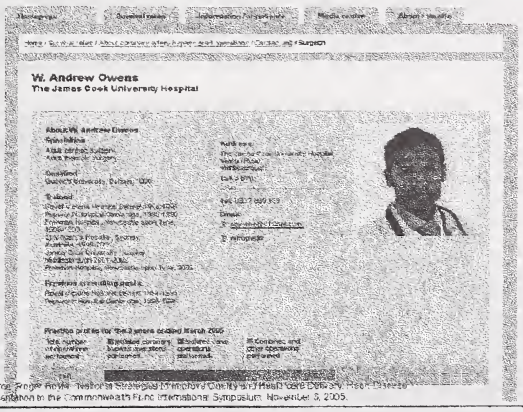
Figure 33. The UK's National Institute for Health and Clinical Excellence (NICE): "Virtual" Institute



Source: Peter Littlejohns. "Using evidence to drive pharmaceutical policy: a NICE experience." Presentation to the Commonwealth Fund International Symposium, November 2, 2005.

Heart surgery in Great Britain

Figure 34



Source: Roger Royle. "National Strategies: Improving Cardiology and Heart Disease Services." Presentation to the Commonwealth Fund International Symposium, November 3, 2005.

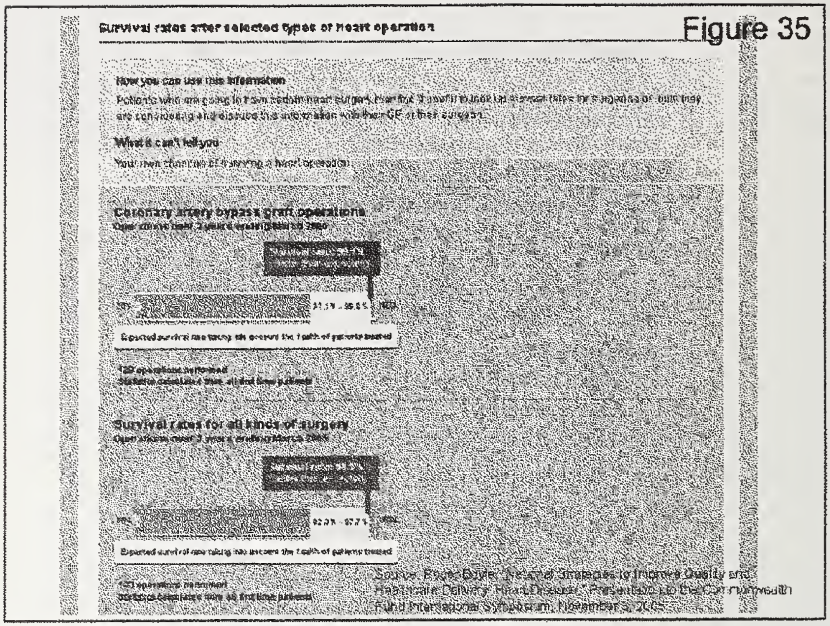


Figure 35

These are just a few examples of innovative practices that the United States might wish to investigate more closely and potentially adapt. Most, however, require leadership on the part of the central government to set standards, ensure the exchange of health information, and reward high performance on quality and efficiency.

CONCLUSION

If we have the world's costliest health system yet still fail to provide everyone with access to care—and fall far short of providing the safe, high-quality care that it is possible to provide—the conclusion that there is room for improvement is inescapable.[30] Only by facing this fact squarely and putting into action the best ideas and experiences across the United States and around the world can we achieve a vision of American health care that includes: automatic and affordable health insurance for all, accessible care, patient-responsive care, information- and science-based care, and commitment to quality improvement.[31]

Achieving a high-performance health care system—high-quality, safe, efficient, and accessible to all—will require a major change in the U.S. system of delivering health services.[32] Steps toward this goal include:

- Extending health insurance to all, in order to improve access, quality, and efficiency;
- Assessing innovations leading to high performance within the United States and internationally and adopting best practices;
- Organizing the care system to ensure coordinated and accessible care to all;
- Increasing transparency and rewarding quality and efficiency;
- Expanding the use of information technology and systems of health information exchange;

[30] K. Davis, S.C. Schoenbaum, K.S. Collins, K. Tenney, D.L. Hughes, and A.M.J. Audet, *Room for Improvement: Patients Report on the Quality of Their Health Care.* (New York: The Commonwealth Fund, Apr. 2002); K. Davis, C. Schoen, S.C. Schoenbaum, A.J. Audet, M.M. Doty, A.L. Holmgren, and J.L. Kriss, *Mirror, Mirror on the Wall: The Quality of American Health Care* (New York: The Commonwealth Fund, forthcoming).

[31] K. Davis, C. Schoen, and S. Schoenbaum, "A 2020 Vision for American Health Care." *Archives of Internal Medicine* Dec. 2000 160(22):3357–62.

[32] The Commonwealth Fund Commission on a High Performance Health System, *Framework for a High Performance Health System for the United States* (New York: The Commonwealth Fund, Aug. 2006).

• Developing the workforce required to foster patient-centered and primary care; and
• Encouraging leadership and collaboration among public and private stakeholders dedicated to achieving a high performance health system.

These steps would take us a long way toward ensuring that the United States is a high-performing health system worthy of the 21st century. Thank you very much for the opportunity to join this panel. I look forward to learning from my fellow panelists and answering any questions.

(Acknowledgments: Research assistance from Alyssa L. Holmgren, Research Associate, The Commonwealth Fund; comments from Cathy Schoen, senior vice president for research and evaluation and Robin Osborn, vice president, The Commonwealth Fund; editorial assistance from Barry Scholl and Chris Hollander.)

Chairman KENNEDY. Thank you very much.

Debra Ness, we thank you for joining with us and look forward to your comment.

STATEMENT OF DEBRA NESS, PRESIDENT, NATIONAL PARTNERSHIP FOR WOMEN AND FAMILIES, WASHINGTON, DC

Ms. NESS. Thank you, Chairman Kennedy and Senator Enzi, for this opportunity and for your leadership.

The National Partnership has been working for more than three and a half decades to improve the lives of women and families through our work on issues around work and family in health care.

If there is one key point I'd like to leave folks with today, it's that I believe that cost, quality, and coverage have to be addressed as a package deal. They are inextricably linked. And if we don't both control costs and improve quality, we're never going to be able to expand coverage to all Americans.

I'd like to focus on four things that I think Congress can focus on to help get us to that place. One is that we need to significantly fix our payment system. Second, we need to——

Chairman KENNEDY. Could you say that again? Fix our?

Ms. NESS. We need to fix our payment system.

Chairman KENNEDY. Payments.

Ms. NESS. We need to realign the payment system. Second, we need to increase transparency. And by that, I mean we need to measure quality, and publicly report it. Third, we need to get on with comprehensive adoption of health information technology—interoperable, secure health information technology. And finally, we have to help consumers make better health care decisions, and we need to do that by getting them better information to make those decisions and through the right kind of incentives in our benefit design.

I'm going to spend a couple of minutes on our payment system.

Our system, right now, has all the wrong incentives. In fact, we actually perversely reward some of the very things that drive up costs and undermine quality, causing people to get the wrong care or unnecessary care all too much of the time. Let me give you a couple of examples.

We know how important it is to have primary care and coordination of care front and center, particularly as more and more people have chronic conditions. As the population ages, this becomes more and more of a problem. We know what the expense of silo fragmented care is. But we have a system that rewards specialty care and technology at the expense of primary care. I'll give you an example. Technology has enabled gastroenterologists, for example, to

do colonoscopies in a fraction of the time they used to be able to do it. They can do a lot more of them. But today we pay a gastroenterologist 274 times what we pay a primary care practitioner for the same half-hour of care. And that practitioner could be sitting in front of somebody with a series of complex conditions—asthma, diabetes, heart conditions—and they are getting a fraction of the pay.

Second thing I want to focus on is, the system rewards volume. It rewards volume—more care—as opposed to, necessarily, outcomes and appropriate care. Some of us have probably heard about Elyria, Ohio, also known as "The Stent Capital of the United States." Researchers discovered that Medicare was paying for stents to be put in patients at four times the national rate. There's no real understanding of why that's happening. Nobody is accusing the doctors in Elyria, Ohio, of inappropriately delivering care. But we don't have any evidence that those patients are doing any better than patients who are being treated with less-invasive methods, using medications, and we do know that Medicare is paying $11,000 for every one of those stents that gets put into a patient. It's clear that medical decisions are often as much influenced by financial incentives as they are by evidence of what's in the best interest of patients.

There is lots more evidence of the way in which we reward volume. Miami, for example, we pay twice as much for Medicare patients in Miami than we do in Minneapolis, but the outcomes aren't any better; in fact, the outcomes in Miami tend to be among the worst. And the biggest correlation researchers could find was between the number of specialists that—Miami had 40 percent more specialists than Minneapolis does.

And finally, I'd like to say that we also, when we pay for care, don't make any distinction between good quality and bad quality care. I often say this to people. I say, "You know, think about it. When you pay for health care, you pay the same amount whether it's good or bad, and if they make a mistake, you pay for the do-over." In health care, we have done little to distinguish between good quality and bad quality. Recently, there's been a lot of focus on pay for performance. Pay for performance is not the only answer, but it is one of the things in which we are seeing some pretty dramatic results. And CMS recently did a major demonstration project with Premier Hospital System, and, in less than a year, is showing that, as a result of the pay-for-performance program, patients are getting better-quality care, costs are going dramatically down, lengths of stay have been shortened. It's a win-win for everybody. So, payment drives quality in very significant ways.

The other two very interrelated elements here are the need for transparency and the need to implement HIT. And, Senator Enzi, Senator Kennedy, I thank you for your leadership on HIT. For sure, that is another way to reduce costs, it's another way to ensure coordination, it's another way to improve quality. Transparency, another way to make sure that people can make the right decisions, another way to drive quality. We have lots of evidence that when you measure quality, it improves; and when you measure and then publicly report it, it improves even faster.

And finally, when it comes to helping patients make better decisions, if we don't make the system more transparent, we'll never get to that point. I understand the desire to get patients to appreciate and make thoughtful decisions about their health care dollars, but it's hard to ask people to make good decisions when they don't have good information about costs and quality, when they can't make those kinds of comparisons. We have a long ways to go before patients have that kind of information.

In addition, we need to keep in mind that most patients make their decisions based on what their doctors recommend. So, if we really want to influence the decisions that patients are making, we need to go back to the payment system and how it's rewarding its providers.

And finally, there is very encouraging research that when you give patients information that allows them to make a shared decision with their physician, and they have information about their options, their alternatives, they tend to make more conservative decisions that are less costly, and, in the end, generally better outcomes. So, there's a great deal of future in giving consumers better information. They, too, can be a part of reining in costs and improving quality, but we have to get to that place.

Thank you.

[The prepared statement of Ms. Ness follows:]

PREPARED STATEMENT OF DEBRA L. NESS

Good morning. Chairman Kennedy, Senator Enzi, and members of the committee, thank you for the opportunity to testify today at this important hearing on health care reform. My name is Debra Ness and I am President of the National Partnership for Women and Families. The National Partnership for Women & Families is a non-profit, nonpartisan advocacy organization with more than 30 years' experience promoting fairness in the workplace, access to quality health care, and policies that help women and men meet the competing demands of work and family. Over the past decade, the Partnership has advocated for sound reforms for our health care system to help the uninsured and promote quality health care for all Americans.

Our health care system is broken. The costs are unsustainable, and the burden falls most heavily on consumers. Since 2000, average premiums have risen 87 percent, while workers' earnings have only grown 20 percent. As a result, our employer-based system of coverage is unraveling, and we are faced with historic levels of Americans who lack health insurance, or live in fear of losing the coverage they have.

We must act, and we must act quickly. But costs, quality and coverage are inextricably linked, and if we don't both control costs and improve health care quality, we can never successfully extend coverage to all Americans. There are four tasks we must accomplish to achieve that goal: We must fix our payment system; increase transparency by measuring and publicly reporting quality; implement nationwide, interoperable health information technology (HIT); and help consumers make better health care decisions through the right kind of tools, information, and health plan benefit design.

I. FIXING OUR PAYMENT SYSTEM

Our current system of paying for health care is in need of dramatic changes. In too many cases, the system perversely rewards the very things that drive up health costs and undermine quality, causing millions of patients to get care they don't need, or, worse, care that makes them sicker. Today, fully ⅓ of our health care spending is wasted on payment for medical mistakes and poor quality care. We also have a system that values expensive technology over the basic primary and preventive care that keeps people from getting sick in the first place, rewards volume of care over outcomes or appropriate care, and makes no distinction in payment based on quality or health outcome.

As our population ages and a growing number of Americans suffer from multiple chronic conditions, it is critical for our health care system to ensure that people get

high quality primary care and that there be good coordination of care. But the reimbursement methodology of Medicare and private insurers advantages specialty care at the expense of primary care and care coordination, resulting in exploding costs as they pay huge sums for services and technologies to treat diseases that could have been prevented or controlled. For example, technology has made it easier and faster to perform colonoscopies. Many gastroenterologists will perform thousands of them during the course of their careers, as many as 10 in a day. And they are rewarded by a system that provides a gastroenterologist with a payment that is 274 times the amount a family practitioner would get for the same 30 minutes of time. And that family doctor could be treating a patient suffering from diabetes, heart disease and asthma, requiring extensive patient education, coordination of care, and monitoring.

In addition, our payment system rewards providers for delivering a high volume of procedures and services, regardless of whether those procedures and services are necessary or appropriate. For example, in Elyria, Ohio—recently tagged as the "stent capital" of the United States—Medicare beneficiaries are receiving angioplasties at four times the national rate. While no one is claiming doctors in Elyria are intentionally providing inappropriate care, there is no evidence that their patients are better off than patients in other parts of the country who are treated less expensively and less invasively. We do, however, know that Medicare is paying $11,000 for each angioplasty.

There are many such examples of extraordinary geographic variations in care, costs and outcomes throughout our country. For example, Medicare pays twice as much to care for beneficiaries in Miami as it does for beneficiaries in Minneapolis. And yet the outcomes in Miami are no better than those in Minneapolis—in fact, by some measures they are significantly worse. Assessed on 3 main categories of care—heart attack, pneumonia, and congestive heart failure—the Miami area was among the 5 worst regions of the country for the care of heart attacks and pneumonia, and was only 29th out of 40 regions for the treatment of congestive heart failure. In analyzing these types of regional variations, researchers have concluded that the volume of services patients receive and the cost of care in an area are highly correlated with that area's concentration of specialists. Miami, for example, has 50 percent more specialists than Minneapolis.

Study after study has shown that unnecessary care is rampant. But our payment system encourages it, and it is clear that care is often influenced as much by financial incentives as by medical decisions. For example, when the State of Florida lowered provider payments for workers' compensation treatment, doctors responded by finding more treatments to perform on each patient. I do believe that most physicians want what is best for their patients, but given the way our payment system is structured, is it any wonder that providers act, and patients often think, that "more is better?"

Our payment system also makes no distinction between good and bad quality care. We pay the same amount even if poor care is provided. And we often pay more for errors that result in extra days in the hospital or in readmissions. For example, research in Pennsylvania showed that individuals who acquire infections while in the hospital cost on average $185,260 to treat, and remained in the hospital for an average of 20.6 days. At the same time, individuals who did not acquire such infections cost on average $31,389 and stayed in the hospital an average of 4.5 days. The Centers for Medicare and Medicaid Services (CMS) has taken some steps in the right direction. Under the Deficit Reduction Act of 2005 (DRA), starting in fiscal year 2008, they are required to adjust payments for hospital-acquired infections. CMS is also reviewing its administrative authority to reduce payments for "never events," and to provide more reliable information to the public about when such events occur.

In recent years, there have been numerous initiatives to reform the system by linking payment to quality. Such efforts are often referred to as "pay for performance." A CMS-run demonstration project with the Premier hospital system has provided groundbreaking evidence that changing payment incentives can generate better patient care, reduce costs, and save lives. Hospitals in the demonstration were required to report on their performance on a series of quality measures for patients with conditions such as heart disease and pneumonia. Those hospitals that performed the best received a higher payment than others. The results were dramatic. In just one category alone, coronary artery bypass grafts (CABG), the results showed that better care costs less to treat (an average of $30,000 as opposed to $41,000), patients were seven times more likely to survive, had fewer complications (4 percent versus 11 percent), and spent less time in the hospital (9 days versus 13.5 days). The Premier demonstration strongly suggests that true payment reform

can not only save billions of dollars but also drive significant improvements in quality.

It is time to re-align the incentives in our payment system to ensure that we encourage and reward delivery of the right care, at the right time, for the right reason, and at the right price.

II. TRANSPARENCY

Payment and quality are inextricably linked. "Quality" is really making sure that every patient gets the right care, at the right time, for the right reason. And improving the quality of care is essential if we are going to control our exploding health care costs.

Unfortunately, quality in our health care system today is, in a word, lousy. The average American patient has no more than a 50–50 chance of receiving the right care for his or her condition. Every year, close to 100,000 lives are lost because of medical errors. And ⅓ of our health care spending is wasted on unnecessary or poor quality care.

The good news is that there are strategies that we know can improve quality. Measuring quality and publicly reporting the results have been shown to drive dramatic improvements in our system. "Measurement" must, of course, be premised on evidence-based best practices, and the measures used should provide meaningful information to consumers. Quality information should be publicly reported in a manner that enables comparison and helps consumers make better choices about providers.

Measurement and public reporting are proven strategies. For example, individuals enrolled in health plans that measure and publicly report performance data were more likely to receive preventive care and have their chronic conditions managed in accordance with clinical guidelines based upon medical evidence. In 2005, for patients enrolled in private health plans accredited by the National Committee for Quality Assurance (NCQA), there was improvement in 35 of 42 nationally accepted (HEDIS®) measures. And in many cases, the improvement was dramatic. In 1992, 62 percent of heart attack patients received a beta blocker upon discharge. Today, 96 percent do.

Similarly, just 3 years after New York adopted a public reporting system for data and outcomes on coronary artery bypass surgery, the mortality rate dropped by 41 percent. And as I mentioned, the Premier demonstration data from year one show significant improvement in the quality of care across the five key focus areas of: acute myocardial infarction, heart failure, CABG, pneumonia, and hip and knee replacement.

III. ADOPTION OF INTEROPERABLE HEALTH INFORMATION TECHNOLOGY

To effectively improve quality, we need comprehensive adoption of interoperable, secure and confidential health information technology (HIT). It is the essential platform for transparency. Specifically, it will speed the development of quality measures that are useful to providers, patients, and payers, ensure the automation of public reporting of current and future measures, and accelerate the clinical decision support that can actually improve performance. Further, emerging technologies offer us an unprecedented ability to provide accurate and actionable medical information in a secure and private form when and where it is needed, whether by patients themselves or the clinicians who care for them.

HIT can also reduce medical errors and generate huge cost savings. Researchers at RAND found that computerized physician order entry (CPOE) could eliminate 200,000 adverse drug events and save about $1 billion a year if installed in hospitals. And about two-thirds of preventable adverse drug events could be avoided through widespread use of ambulatory CPOE. The same study concluded that HIT could generate savings for both inpatient and outpatient care of $77 billion or more per year.

But the development and adoption of HIT is futile without the trust and cooperation of patients. For this, assurances that electronic health records are kept private and secure are essential. Yet today, consumers have little such assurance. To date, the Department of Health and Human Services (HHS) has received over 23,000 complaints about privacy violations under the Federal Privacy Rule promulgated under the Health Insurance Portability and Accountability Act (HIPAA). Yet the agency has failed to impose a single civil fine. Is it any wonder that consumers don't have confidence that their medical information will be protected if it is entered into an electronic record? Any policies affecting the development and adoption of HIT must include appropriate safeguards to ensure the privacy and security of individ-

ually identifiable health information. Further, any violations of privacy or security that violate HIPAA should be actively investigated and enforced.

IV. CONSUMER DECISIONMAKING

All consumers should be in a health benefit plan that creates incentives for patients to get the right care, at the right time, for the right reason. The plan should encourage and reward patients for seeking primary and preventive care, and should encourage providers to provide appropriate care coordination and follow best medical practices for the care of chronic conditions.

But not all so-called "consumer-directed" health plans are created equal. Many of us approach "consumer-directed" health care such as health savings accounts (HSAs) with cynicism, because little about it is truly consumer-driven. Rather, much of it appears to be simple cost shifting from employers or health plans to individuals. This kind of approach not only does not solve the problem of rising costs and poor quality in our health care system; it actually makes it worse. First, encouraging HSAs won't help us reduce the rising costs in our system because so much of health spending is non-discretionary. Studies have shown that 5 percent of our population is responsible for almost 50 percent of our health care costs. These are not people deciding whether to spend their deductible on a flu shot or dentist appointment. These are individuals with chronic, complex conditions who would quickly exhaust the deductible in any high-deductible plan. Further, research has shown that consumers in HSAs tend to get less care, especially the kind of primary and preventive care that can help them stay healthy or avoid more serious illnesses. And because of their tax incentives, HSAs tend to attract the wealthy and healthy, skewing the risk pool for those in traditional insurance, and leaving those most in need behind.

Some say that consumers need "skin in the game" in order to help bring health costs down. Presumably the notion is that consumers who have a greater financial stake in their care will not seek unnecessary treatments and choose providers who are the most cost-efficient. But consumers can't make good choices without good information, and good information just doesn't exist today. Consumers have access to almost no comparative data on either the price or quality of care. Patients can learn more about the quality of a toaster oven than they can about their local hospital or doctor. This is wrong, and consumers have a right to know where they can get the best care for their family.

In the absence of other information, consumers will rely on their doctor's advice. But we know that our payment system often encourages doctors to have a "more is better" mindset; a mindset often passed on to patients. We need to better educate consumers so they can participate in shared decisionmaking with their physician. Research has shown that when consumers have accurate information about treatment options and alternatives, they tend to make more conservative, less invasive, and less costly decisions. And those decisions often result in better outcomes.

Consumers need good, reliable information about both the cost and quality of health care. They simply cannot make educated decisions without it. And we cannot ask consumers to decide solely based on cost information. Would anyone ask a new mother to just go out and find the cheapest pediatrician? Or a heart attack victim to find the cheapest cardiologist? Good information about both quality and cost must be available for consumers to make true, value-based decisions about how and where to spend their health care dollars.

V. CONCLUSION

I believe everyone here today has the same goal: for every American to have access to high quality, affordable care. And I would urge you, if there is one thing you remember from the hearing today, remember that lasting health care reform must tackle cost, quality and coverage as a package deal. If we focus on the four things I discussed today: fixing our payment system, promoting transparency, implementing HIT, and helping consumers make better decisions, I believe we can make enormous progress toward achieving our common goal.

Mr. Chairman, members of the committee, thank you for the opportunity to join in this roundtable today and I look forward to our discussion.

Chairman KENNEDY. Thank you all very much.

I'm struck by how much agreement we've heard from a diverse set of witnesses. All our participants agree on some very basic points—Federal bipartisan leadership is essential; the importance of health IT is crucial in containing costs; the emphasis on reward,

encouragement, and quality, and renewing and expanding the CHIP is very important, as is transparency, information to patients, comparative effectiveness. The reducing of fragmentation and administrative costs in a number of different areas, is also very useful and very important.

Let me get back to the witnesses, and we'll ask all of our colleagues to chime in here. John, in the area of ERISA—and I'd also be interested in hearing from the Business Roundtable and others—what are the real inhibitors that the States are going to find, in terms of ERISA? What should we know? We've heard comments about what's happened in Massachusetts, and what's happening in California. We know other States, such as Vermont, have taken some initiatives. Is there some general guidance you can give us about the existing inhibitors for States to move ahead? I mean, what can you tell us about it?

Mr. McDONOUGH. Well, there are two principal impacts of ERISA, one we think is entirely appropriate, which is setting national standards, so States don't go and micromanage what employers have to offer, when they offer coverage. And so, we have no objection with establishing that national standard. The concern is, when a State, for example, wants to create a level playing field so that employers who offer coverage are not being required to subsidize employers who don't, implicitly or explicitly, ERISA prevents a significant legal roadblock to doing that and to creating a broad, even, fair level of employer responsibility. And so, you create, then, essentially a reward for employers who engage in the race to the bottom, in terms of reducing their benefits, and end up shifting those costs onto States and onto other employers. So, it's a real impediment. It's a foggy area. It keeps getting thrown back to the courts, most recently in the Maryland case, and there's a lot of uncertainty. And so, some ability on the part of States to have a clearer sense of what we can do and what we can't do, and to be able to hold employers to some level of basic responsibility, we think, is critically important, moving forward.

Chairman KENNEDY. If there are members here on the panel who would like to make a comment on any of this, just raise your card.

Larry.

Mr. BURTON. Just a response. We believe that ERISA has been important, because our employers, which are basically large employers, operate in multistates. And so, it does help have a common basis of a plan. If we were forced to go to each State and develop individual plans in each State, it could be very, very costly. So, I think the unknown is the big question there.

Chairman KENNEDY. John, did you want to make a comment?

Mr. GOODMAN. We have a different problem with ERISA. I didn't hear anybody today talk about portability, but I think this is going to be the next really big problem in health care. People need to be able to take insurance with them as they go from job to job. And the ERISA law, as now written, creates a problem for any employer that wants to buy insurance for his employees—that they own and they can take with them. And it's uncertain about what they can do. And that, I think, has blocked a lot of States from being more aggressive in creating opportunities for portable insurance.

Chairman KENNEDY. Michael, do you want to ask any questions?

Senator ENZI. I, too, want to thank the panel for a lot of information. And I assume you realize that, by volunteering to be on this panel, that you're also willing to answer some additional questions that we might submit to you later, because there are some details that we won't cover here, but that we may need information on to come up with significant legislation, and that is what we will try to do.

I do appreciate the emphasis that there's been today on Health IT from virtually everybody. We recognize that. We put that through as one of the first bills that we did, and we tried, up to the last minute of last year's lame-duck session, to get that through. It got bogged down in a whole lot of additional issues that will have to be covered at some point, but our hope was that we could get the interoperability piece going immediately so that the communications system would work between doctors, patients, pharmaceutical companies, hospitals, and all providers. And, of course, we did run into some Federal laws that create some problems there, but we're sure we could work that out as a second part later, and then even a third part, where we could address the costs.

But we were very encouraged to find out that the interoperability, just in Medicaid, Medicare, and veterans alone, would produce a savings of $160 billion a year with a one-time infrastructure cost of $40 billion. That's good investment anywhere. That's better investment than anybody can get anywhere. And that doesn't even take into consideration the savings in the private sector.

So, I really appreciate the information, the encouragement, and the explanation of what can come out of Health IT. It's those results that we're really looking for. And a lot of that's the transparency and the ability to make better decisions, which is also what scares a lot of the health care providers.

I hope, as the California plan develops further, that our panelist who spoke on that will share that information with us. We already have good information, both from Senator Kennedy and from Massachusetts, on the Massachusetts plan. And we are trying to find some kind of a solution that's going to provide people with quality health care, hopefully at a lower price.

I do have one more question here that I'll just throw out. Perhaps it'll come as a written answer. We're considered, in the United States, to have the cutting-edge technology in medical care, and yet, the health indicators are better other places in the world. Why? How? I'll just leave that rhetorical, and hope you'll respond to me individually on that one.

Senator ENZI. I appreciate the information on the Danes and what they're doing, and I want to get some more information on that piece of it.

Ms. DAVIS. I think one key is that other countries put a lot more emphasis on permacare. We have about the same number of physicians per capita, but they have a much higher share of permacare. And they make that free and accessible. You can get it the same day, so you catch problems early, you get the preventive care. We put a lot of money into the costly high-end specialized care, where we get a lot of duplication, fragmentation, errors—we have higher error rates than other countries. So, I think one key is really hav-

ing a medical home, that physicians are rewarded for taking responsibility for patients and they help ensure that they get the preventive care, and they coordinate their care.

Chairman KENNEDY. Anyone else want a chance?

Senator Sanders.

Senator SANDERS. Thank you, Mr. Chairman.

I would just concur with those who have suggested that our health care system is not just in trouble, but it is disintegrating. I think the charts that the Chairman showed us tell us a whole lot, but, in many ways, they understate the case, because it's not just the number of people who are uninsured, it's the number of people who are underinsured, who do have health insurance, but it is inadequate health insurance.

It seems to me that, of all of the excellent testimony—and all of the people who have spoken have made important contributions—I think Karen has raised some important issues, in that, Why is it that, in the United States, where we are spending almost twice as much per capita on health care as any other country, we remain the only Nation in the industrialized world that does not guarantee health care to all people? And, as Senator Enzi indicated, that many of the indices, in terms of quality, are not as strong as in other countries. And I think it is very important for us to take a look at Denmark, Scandinavia, Europe, and see what they are doing, in fact, that we are not doing. And I think one of the components of what they are doing is saying that all people are entitled to health care as a right of being citizens of their country.

Now, I am not optimistic, for a variety of reasons, that, here in Washington, we are going to pass a national health care system. The opposition is just too strong. But picking up on John's point, earlier, I do think that States are laboratories for change, and I would hope that many of us can come together, from whatever our ideological perspective might be, to say, "Look, maybe the Massachusetts is working well, maybe it's not; maybe Vermont wants to go to a single-payer model, maybe it doesn't; but why don't we give States the option to experiment and to look at different concepts, see what works, see what doesn't work?" If we can't do it in Washington, at least give States that opportunity.

I thank you, Mr. Chairman.

Senator ALLARD. Thank you, Mr. Chairman.

I want to pose a question as—you know, to think about—is, How, by just merely expanding coverage, do you really bring down the cost of health care? I've had the experience of a small businessman, and, as a small businessman, I was an intensive shopper. And I found that, in my employees, some of them didn't want to use my health insurance, because they had a better policy either within the family—I had young employees—whether it was in the family or, perhaps, maybe their spouse had a better policy than what I could offer. And so, they didn't do that. So, there was a sense of fairness between another employee that I had that we paid health insurance for and those who got their health insurance coverage outside the business. And so, I was concerned about a fairness issue, wanting to pay my employees for their productivity.

The other things that I ran into is that I found that just because you have group coverage doesn't mean it's less expensive. Some-

times individual coverage is less expensive. And so, you have to watch your costs. Sometimes you start out with coverage that is relatively low, but, over the years, some companies increase their premium rates faster than others, and so, they become noncompetitive, so, as the small businessman, you have to watch that.

The other thing that I found out is that—I got frustrated with the high cost of health care. I decided that me and my wife would set aside a cash account in our family to pay for health care costs. So, I had a hard time getting to the hospital when I needed surgery, but, once I got in there and got out, I got a 15-percent discount because I paid it, cash.

So, my question, again, is, How is it, by increasing coverage, do we reduce the cost of health care? And I think, as a small businessman, what we need to do is, we need to give small business people lots of choices. The more choices they have, the more they can deal with the market.

Mr. MEADE. I'll be glad to provide you with some analysis that we have done on this. But let me say, at the beginning, for those who don't have insurance, health care is more expensive and inadequate. At one of our hospitals that Senator Kennedy is very familiar with, Boston Medical Center, began an experiment in the last couple of years, where they gave people who were coming regularly and using the uncompensated care pool a card for that hospital and started making regular appointments for people. And they found a dramatic drop in the cost of health care to those folks. So, far too many of the people who don't have coverage end up going to extreme cases and being treated in the most expensive way possible, beginning at the threshold of the emergency room.

I do think Debra put her finger on what we need to do, and we can't look at just one part of the health care system. We do think you can lower cost if there is—the three stools that she spoke about: cost, quality, and coverage. People like Don Berwick and others at IHI have done a lot of work saying that at least a third of the care we presently get may be inadequate, and the significant overuse, misuse, and underuse in health care, we think, is an important part of this. So, I'd like to provide you with some information on the analysis that we have done, and share that with the committee, as well.

Chairman KENNEDY. Peter Harbage.

Mr. HARBAGE. Thank you. For better or worse, health insurance is how people in this country truly access health care. And so, by expanding coverage, that's how you're able to get access to a medical home, to smoking cessation, to obesity programs, because, as Peter just said, right now when you're—uninsured you're most likely to present in the ER and have very costly and very inadequate care. So, that's one way universal health coverage will bring down cost. The other is that on a societal basis if everyone pays a little bit more the cost will come down for everyone else. The concept of a hidden tax that the people with insurance are paying for the unisured is something that Families USA has talked about, it's something that New America has talked about. And so if everyone—if the uninsured just start paying in a little more you can start to capture some of that savings back and reduce the cost of

insurance for people who are buying it today. Governor Schwarzenegger has taken to calling that the coverage dividend.

Mr. ANTOS. Well—if you—I think the Senator's point is quite right, if you want to phrase it as if you want change you have to make change. So simply doing what we are doing is not going to do it. I'd make the comment that we have to be careful about what cost means. If all we do is hide the cost—which is what we often do—if we just hide the cost we hide it in taxes, we hide it in higher premiums. We haven't actually addressed the real cost problem. The real cost problem is the use of resources to produce, as Karen says, less than ideal outcomes. And so that's what we need to be focusing on. If we only concentrate on what I would consider to be sort of phoney financing mechanisms we will lose the battle. We have to do what Deborah was talking about.

Mr. GOODMAN. I agree with the question. At Parkland Hospital in Dallas, the uninsured patients, the Medicaid patients, the SCHIP patients all come through the same emergency room door, they all see the same doctors, they all get the same care. In fact, RAND Corporation says, nationally, once people get into the system, they get the same care, regardless of the insurance they have. But, in any event, at Parkland, there are paid employees who go through the room and actually try to sign people up to get them on Medicaid or SCHIP. So, the question is, once they sign that piece of paper, does their care become better? Do our costs go down? Of course not. And so, I think that we have become so focused on the formality here, because hospitals and other very important institutions care about the money flows, but we're not going to change the quality of care, or the efficiency with which it's delivered, unless we give people different options in the medical marketplace.

Chairman KENNEDY. Brief comment, John?

Mr. MCDONOUGH. I was just saying with all respect, we do what we can to get access to the emergency room. And there is an abundance of evidence that by not having health insurance these people get sicker and die sooner and in these—emergency room and what you get in the emergency room——

Mr. GOODMAN. OK, it turns out that what you just said is true, there are hundreds of studies that concluded that lack of insurance leads to worse care. Turns out, they're all bad studies. And when the RAND Corporation did this the right way, which is to ask, Among people who see doctors, who access the system, is there then any difference in care? And the answer is, "no". And why is this important? Because if we just enroll people in Medicaid, but the rates are so low that their only opportunity to get health care is at the emergency room, we don't lower costs and we don't improve quality.

Chairman KENNEDY. Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

In the State of Alaska now we're looking at about 18 percent of our population that's uninsured, but we also recognize that there's a good portion of those folks that can afford insurance who are just opting not to. So, we're looking at what's going on in California, in Massachusetts, in Vermont, and you look to the possibilities that can come out of these State initiatives. And I agree that we do need

to encourage the State initiatives and, kind of, figure out how those are going to happen, but I've also heard that the Federal assistance would be helpful, would be welcome.

Well, usually when we step in, we have a desire or an attitude to, kind of, impose a one-size-fits-all, and, kind of, see this, to a certain extent, in education. All the States are doing their own thing, we step in with No Child Left Behind, and you've got, kind of, a one-size-fits-all approach to it.

The question I'm concerned with, particularly coming from a State like Alaska that has very unique health care challenges as it relates to access not only to health care insurance, but access to providers, is how we can be of assistance at the Federal level without giving that directive to the States, when you all are, to a certain extent, trying to figure it out on your own. How far do we come into the picture?

Mr. McDONOUGH. Senator, I would just suggest looking at the SCHIP program as a prototype, where you are not creating a one-size-fits-all program, you're giving States an array of choices, not a limitless number of choices, but some States wanted to do it just through their Medicaid program, some States wanted to set up a unique, distinct, special Children's Health Program, and some States wanted to do a hybrid. So, I think there's a good model for you, in terms of looking at that, which is, don't do it one-size-fits-all, give some array of options, and not a limitless number of options.

Chairman KENNEDY. Ms. Ness.

Ms. NESS. I just want to add into this discussion the fact that the Federal Government is the largest purchaser of health care. Through Medicare, through Medicaid, through its other public purchasing programs, it really sets the tone for what a lot of the private sector does. And so, I think we need to think both of how the Federal Government can support what's going on in the States, and encourage the innovation, while, at the same time, being sure that, at the Federal level, Medicare is being innovative, itself, in setting the stage for the kinds of reforms that, if the private sector would follow, could make a huge difference, both in the States, in what they do, as well as in those public programs.

Ms. DAVIS. If I could just respond, I don't think the States can do this on their own and sustain it without Federal help. Obviously, if the Federal Government would just put up matching money for, say, adults below 150 percent of poverty or children below 300 percent of poverty, it would help many States move forward. Massachusetts had a waiver, they had a low rate of uninsured, because they had high employer coverage in the State, but, for other States, I think making the offer of some Federal matching funds that was significant for the low-income uninsured population would make a big difference——

Senator MURKOWSKI. To offer Federal assistance a lot of places——

Chairman KENNEDY. All the more reason, on the SCHIP, to increase funding for the reasons that have been outlined.

Senator Coburn.

Senator COBURN. Thank you, Senator Kennedy.

One of the things I heard consistently is, Make sure we allow the States to experiment. I think everybody, all of our panelists, agree to that, that there needs to be this ability to try different things, and we should not be hindering that at the Federal level.

You know, the estimates are anywhere from a third to a fourth of the health care dollars that we spend aren't spent on health care. And I'm interested to know—you know, we had a broad spectrum of position and viewpoint here today—is, How do you squeeze the one-third to one-fourth out? Do we do it by regulation? Do we do it by management? Do we do it by manipulation? Do we do it by mandates? Or do we do it like we do it in every other area in this country, except in education and health care, is market forces? And I—you know, we hear comments about how well Medicare and Medicaid does, from an administrative standpoint, but when you add the fraud and abuse and waste in Medicare, which, this last year, totaled—in Medicare and Medicaid, totaled $85 billion—you get to rates higher than the private sector, in terms of fraud, waste, abuse, and overhead. Do you mandate the amount of profit somebody can make if they sell a product? And what happens to the insurance market as soon as you do that? It goes away.

You know, the one thing that we know we can do in our country—and I want to identify a lot with what Ms. Ness said, because she's right on about what's happening in medicine today, she's right on about the perverse incentives, to overutilize, overtest, overtreat, because of the reward mechanism—but I want to caution us on pay for performance versus payment for best practices. There is a big difference. And the pitfall is, if you're going to pay for performance, the best doctors in our country are going to get canned, because we send our toughest patients to the best, and they have the worst outcomes, because they have the toughest patients. So, we'd better be very careful with this concept of pay for performance versus payment for best practices, and we need to be measuring best-practice utilization rather than performance.

But I'm interested in the comments on how we squeeze this one-third to one-fourth out, because that's the real key. How do—if we're at 16 percent, we should be at 10 or 11 percent, and how do we afford access for everybody—which I totally support—how do we best do that? Do we do it with a Soviet-style-run health care system that we've been experimenting with for the last 40 years in this country, or do we allow what has happened in every other aspect that has increased standards of living, promoted the best research, the best Nobel—the largest number of Nobel Peace Prize winners, the greatest advancements in health care anywhere in the world—80 percent of them have come out of this country—how do we not lose that as we go toward that?

So, I'd be interested in hearing how we squeeze that one-third to one-fourth out, of waste, fraud, and duplication, that we know is there. And we get to go one of two ways. We can go with a heavy handed government-oriented, or we can experiment in the States, come up with a way, and use market forces that have been very beneficial to us in every other aspect, protecting consumers at the same time. And I'd love to hear the response to that.

Chairman KENNEDY. All right. We've got a number of respondents so, quickly.

Larry.

Mr. BURTON. First of all, I think we're all in this together—I think that's the big message you're hearing today—whether it's the government, whether it's employers, whether it's individuals. That's point one.

Point No. 2 is, you cannot underestimate the power of innovation, which is a—something we cannot put any sort of governors on. The efficiency from Health IT is just fantastic. And you heard the numbers. And I think that's there. Next is information to consumers. If they have good information, they can make very informed decisions which are cost efficient. That's going to help the system. And, of course, again, wellness. I think that's unexplored territory which could yield tremendous benefits.

Chairman KENNEDY. Fine.

Joe, quick.

Mr. ANTOS. One of the things that I think you are headed toward, Senator, with your $2 trillion question, has to do with the way health plans and providers operate. And one of the big factors, I think, is that, although there's some risk in the business—in fact, there's an entitlement mentality. Everybody expects to get paid. We argue about how much we're going to get paid. But, in the end, you have a pretty good idea that the dollars are going to come in. And there really needs to be a greater sense that there's accountability for that money, and a greater sense that it isn't absolutely guaranteed. And, as someone said earlier, I think Medicare is a good place to look at that.

Chairman KENNEDY. Peter Harbage, briefly.

Mr. HARBAGE. Briefly, I just wanted to say what you might find in the Schwarzenegger plan. And I think it's really a mix of market forces and government intervention. The plan's based on private insurance, new—it's based on market forces. It's based on the idea that if you can develop a statewide purchase pool, that you can get better efficiencies from providers. On the government side, there's expense in the long-term. He's looking at health information technology, like everyone else. What can be done in chronic care to bring down costs in the long-term and make things more efficient? But, in the short term, there really is the focus on the loss ratio I mentioned in my remarks——

Senator COBURN. Well, let me give you an example. Let's say I'm XYZ Insurance Company, and I really believe in prevention, and I work hard on wellness. What's the reward for me if I have an extra 5 percent? I've done great care for my patients, I've paid for all the bills, and, at the end of the year, because I've done wellness with the same mix of patients, I've got to go spend it all or I give it to the government? You're never going to have that innovation if you mandate what somebody's potential can be. You're going to kill innovation. You're not going to stimulate it, you're going to suppress it. And the thing that we—the one aspect—the only aspect, I think, that's great about our health care system today is, we do have some innovation. I just want us to have more.

Chairman KENNEDY. Peter.

Mr. MEADE. Senator, Blue Cross Blue Shield of Massachusetts is a not-for-profit health care company. We have 3 million subscribers. Over 300,000 of those subscribers are on wellness pro-

grams. And we believe that gives us an advantage to our bottom line, but also makes us more competitive with wonderful competitors in our State. So, we think that's part of it.

One of the things we have to look at is what we pay for, all of us. And being a primary payer, the Federal Government ought to look at it. Just the beginning, never events. The never events ought to be reported by every hospital in the country. The whole issue of how we compare needs to be done.

When we talk about quality—and, yes, we need to be very careful. Just as in education—we need to be careful as we look at special education and the more difficult prospect of educating people like me, who were special-ed folks—we need to look at what happens with difficult patients and what happens with those doctors. But you can set standards, you can measure. And if we don't measure, we'll never be able to manage.

Chairman KENNEDY. But just briefly, I mentioned to my friend and colleague—what has been happening in the VA system, which is use the information technology. IT has helped the VA keep the costs down, improving quality. This has been, really, an extraordinary improvement. They've had some very, very innovative and creative kind of ways of doing some of this that we ought to pay some attention to.

I see Senator Roberts is here. We thank you, our friend and colleague, and member of our committee. Senator Burr and then Senator Roberts, if that's agreeable. And we have a vote at noontime.

Senator BURR. Thank you, Mr. Chairman.

Let me thank each and every one of you for your willingness to come in. I think that there's been a tremendous amount of great ideas, some with—which I agree with, some with—which I've already discounted and, in the past, felt they weren't a direction we should go. But I think the spirit here is the right spirit, and that's—we've got to try something, because if we continue to do what we're doing, we're in big trouble.

I remember when an emergency room was designed to treat emergencies. And a large share of the emergency room today is to deliver primary care. The degree of that depends upon where you are in the country, in many cases. But to help me clarify where everybody is, let me ask three questions. It's yes-or-no answers. I'll go right around. I'll start with John first.

Do you support a single-payer system?

Mr. MCDONOUGH. Yes, among others.

Senator BURR. Andy?

Mr. STERN. [Off Mic]

Senator BURR. Larry?

Mr. BURTON. [Off Mic]

Senator BURR. Pat?

Ms. COMBS. No.

Senator BURR. Peter?

Mr. MEADE. No.

Senator BURR. Peter?

Mr. HARBAGE. It's not politically feasible.

Mr. MEADE. No.

Senator BURR. John?

Mr. GOODMAN. Of course not.

Ms. DAVIS. Impractical.
Senator BURR. Debra?
Ms. NESS. I'd say not politically feasible.
Senator BURR. Let me work backwards this time.
Do you support liability reforms—health liability reforms?
Ms. NESS. Yes, but probably not the same ones that you would. [Laughter.]
Senator BURR. John?
Mr. GOODMAN. Radical liability.
Senator BURR. Joe?
Mr. ANTOS. Yes.
Senator BURR. Peter?
Mr. HARBAGE. It's a very small part of overall health care spending, and California already has some pretty good reforms in place.
Senator BURR. Yup. Peter?
Mr. MEADE. It depends on the reform, Senator.
Ms. COMBS. It depends on where it starts and where it ends.
Senator BURR. Larry?
Mr. BURTON. Yes.
Senator BURR. Andy?
Mr. STERN. [Off Mic]
Senator BURR. John?
Mr. MCDONOUGH. [Off Mic]
Senator BURR. Is that a yes or no?
Mr. MCDONOUGH. [Off Mic]
Senator BURR. Again, working backwards, Do you support pricing transparency? That's for the entire delivery system. It's doctors, it's hospitals, it's insurers.
Andy.
Mr. STERN. Yes.
Ms. COMBS. In other areas, we have. We haven't addressed in this one, at the moment.
Mr. MEADE. Absolutely.
Mr. HARBAGE. Absolutely.
Mr. ANTOS. Absolutely.
Mr. GOODMAN. Absolutely.
Ms. DAVIS. Yes, but transparency——
Ms. Ness. For making cost information available to consumers.
Senator BURR. Great. Now, see how easy it was to find an item that we had a unanimous agreement on?
[Laughter.]
Senator BURR. That, I hope, is where Senator Kennedy is headed with this process. And I believe that he has a history of finding those things where there's total agreement, and then building on that.
In North Carolina, the Medicaid program is now designed around a community care program, a waiver. A State had the option to be creative, and, regionally, we've tried to set up the Medicaid system where it has stakeholders—stakeholders: patients, doctors, health care professionals, hospitals, social workers. But the unique thing was that it's set up to provide a health care relationship with every Medicaid beneficiary. How in the world can you take the most at-risk population, based upon actuarial figures, which is the lower income, and not create a health care relationship, and expect them

to utilize health care in the most cost-effective and the most efficient way? It is impossible. How can we ever talk about successfully addressing prevention and wellness if, in fact, a patient doesn't have a relationship with a health care professional. It doesn't have to be a primary-care doc. It can be an RN, it can be a community health center, it could be a hospital. It depends on where that patient is and what the delivery system looks like around them.

I think we've gotten a lot of great ideas today. It is amazing to me that, since Medicaid is—the majority of the funding for Medicaid is out of the Federal Government—that we would—we don't require every State to require every Medicaid beneficiary to be assigned a primary care provider. If you think about a piece that everybody said, which was education, which was access, which was wellness, which was prevention, if, in fact, you created that relationship, not in a voluntary way, but you—just like Massachusetts requires every person to have an insurance policy. Well, why can't you say to every Medicaid beneficiary, "You've got to have a primary care provider?" What's wrong with that? And I would challenge you that that's just one example of, I think, an easy change that gets at the cost savings that Dr. Coburn talked about. The question is, Do you—can you learn, from that, about other pieces of the delivery system? And that's one that States and the Federal Government have direct jurisdiction over and direct control over.

Did you have something, John?

Mr. MCDONOUGH. Just that, I totally enforce the idea——

Chairman KENNEDY. Microphone, John, please.

Mr. MCDONOUGH [continuing]. The reality is that in many States the primary care system in the United States right now is hemorrhaging. We are losing primary care physicians all over the country, and, in many parts of the country, you simply don't have enough primary care physicians to handle the demand for all of those folks.

Senator BURR. John, I agree with you totally, and that's why I didn't use the term "primary care doctors," because I think that we—as we creatively look at health care and try to figure out how to get our hands around this, you have to creatively look at the delivery system and ask yourself, just like we use generic drugs and—at some point—what's wrong with using RNs? What's wrong with using a community health center? What's wrong with using a hospital for a primary care function if, in fact, the pool of available doctors or nurses, or whatever, is not sufficient?

In full disclosure, Mr. Chairman, I am a little bit influenced on this debate as it relates to having Ms. Combs here, because my wife is a realtor. Therefore, I'm lobbied every day on this issue, and I'm not sure——

[Laughter.]

Senator BURR [continuing]. I'm not sure how that'll be treated under the new ethics rules that we're debating——

[Laughter.]

Senator BURR [continuing]. On the floor.

But I think our attempt here is to acknowledge what many of you said—this is a crisis; Andy, what you said, and that's that American business is not going to be competitive unless we do

something. We may have differences as to what "something" is, but the fact is that we agree that this hurts America, hurts American workers, hurts the American people. And I think there is a real sense that we can begin the process of radically changing health care. If there is one hope that I have—and, I think, many members have—is that we will quit tinkering around the edges of this issue—right or wrong, that we get a hold of some bold changes in health care that provide us the type of information that we need to make the right decisions in the future.

I thank you, Mr. Chairman.

Senator COBURN. I just wanted to followup on that. You know, we can't fix Medicare until we fix health care. We can't fix Medicaid until we—I'm talking about the fiscal mess that's in front of us—until we fix health care. And I think Richard's right, we need to boldly change it. We can come together. The great hope is, this is not an insolvable problem for our country. And if we choose to come together, we can solve this, and we can say—make a tremendous impact, in terms of health care, in terms of the lives of those people out there who don't have it today, in terms of the longevity and quality, in terms of prevention. We are spending billions of dollars in a chronic-disease-system treatment, rather than a preventative treatment, and we need to transform from chronic-disease treatment to prevention treatment. And if we can do that, then I think we can accomplish a great deal for our country.

Chairman KENNEDY. Senator Roberts, we're so glad that you're going to be our wind-up questioner or commenter and give us some pearls of wisdom. You've been sitting back here, looking at all of us here tentatively.

[Laughter.]

Chairman KENNEDY [continuing]. And nodding occasionally.

Senator ROBERTS. I'm just sorry I'm late. And——

Chairman KENNEDY. No, that's——

Senator ROBERTS [continuing]. The nice remarks knowing I'm the last guy——

Chariman Kennedy. Standing.

Senator ROBERTS [continuing]. To—or standing.

[Laughter.]

Senator ROBERTS. That's why I've always thought it might be a good idea to have members sit where members ought to sit, and others sit elsewhere, but——

Mr. Chairman, thank you very much for holding this hearing. I am—over in the Finance Committee, which has a related interest in this.

In Kansas, we have 300,000 people without health insurance. That's a big problem. In Kansas, about 41 percent of our small businesses do offer health insurance to their employees. That's in contrast to 97 percent of larger businesses who offer health insurance. And I know there's been some discussion about universal health coverage—the Massachusetts plan, California plan. And I do appreciate these ideas—as proposals. I do have some concerns about the vast plan to attack vast planning. And that, as a consequence, I'm not sure we should jump into that pool without being very careful. And I am a very strong supporter of Senator Enzi's small business health care plan legislation. I was going to ask Ms.

Combs—and, by the way, Senator Burr, my wife is a realtor, as well, just for competition's sake.

[Laughter.]

Senator ROBERTS. And I sure wish you wouldn't bring it up in context with ethics reform.

[Laughter.]

Senator ROBERTS. I have it on the record I appreciate it.

Chairman KENNEDY. As long as they don't fly in a corporate plane.

[Laughter.]

Senator ROBERTS. Senator Kennedy I was wondering if you can get the Massachusetts plan to cover that cold you had——

[Laughter.]

Chairman KENNEDY. Yeah, Senator Coburn gave me some free advice earlier about this cold, and that is, I don't have to talk quite as much, and——

[Laughter.]

Chairman KENNEDY [continuing]. I'm sure he was relating to my cold.

In any event, thank you.

Senator BURR. Free advice is worth what you pay for it.

[Laughter.]

Senator ROBERTS. I shouldn't say this—as well, I was an acting presiding officer. I had the priviledge to do that when you were speaking sir. And you were speaking and then you were speaking and then you were speaking and——

[Laughter.]

Senator ROBERTS. Your coloration tends to——

[Laughter.]

Senator ROBERTS [continuing]. You act, you ask me—and presiding officer how much time the distinguished Senator for Massachusetts had remaining, I informed you that the distinguished Senator had 11 minutes remaining and that the audio system was working.

[Laughter.]

Chairman KENNEDY. Oh, I always look for good advice from my friend.

Senator ROBERTS. Ms. Combs, if you could do anything, any one thing, that could help a State like Kansas, where we really have a problem in regard to access, really have a problem in regard to any health insurance for our small businesses, what would it be?

Ms. COMBS. Well, I think that we need the ability to have a pool to have our association members in that pool so that we can access more affordable housing.

Senator ROBERTS. I appreciate that. And with that I yield back to the Chairman.

Chairman KENNEDY. Well, thank you very much.

Thanks to all of our panelists. As I think back on Senator Enzi and I, and others who comment, there's a lot of common ground. I don't minimize, and none of us should, the complexities and the problems, and the forces that are out there that resist change. As one who cares deeply, I've thought, like everyone on the panel and all of our colleagues, about this issue for some period of time, and the devil's in the details of these issues. But the American people

are just crying for some focus and attention and for some relief. And I think we've gotten a number of very, very good suggestions. And I think we have a real responsibility to come to grips with them. This is the beginning of a series of issues on this.

I'd like to second what Senator Enzi said about following up. We'll be inquiring, from some of our panelists, some additional kinds of ideas and get your reaction to some additional kinds of questions. But we're very, very grateful to all of you for joining with us this morning. It's been very constructive and very helpful.

I thank my colleagues who have joined with us, and we'll stand in recess.

[Additional material follows.]

ADDITIONAL MATERIAL

Prepared Statement of Senator Clinton

I'd like to thank the Chair and Ranking Member for convening this roundtable. And I'd like to thank all those who have come here today to share their ideas on how we can both reduce costs and ensure that all Americans receive high-quality health care.

As you know, I've done a little work on health care myself, and still have the scars to show for it. In the years since I first became involved in this issue, the problems confronting our system have only grown.

Costs have continued to rise, the ranks of the uninsured have increased, and strains on our system and its ability to provide quality care have worsened.

But before we begin to explore those, I think it's important that we first take a look at what's right about America's health care system. We can learn how to fix some of the problems by drawing on the strengths of our current system.

First and foremost we have dedicated, skilled, caring doctors, nurses and other health care personnel. We have medical innovation that is second-to-none.

And in recent years, we have seen communities engaging in local innovation, bringing together business, patients, and medical leaders to try and hold down costs and make sure those who need care get it.

While I may not agree with every policy detail of the Massachusetts law or the California proposal they deserve enormous credit for stepping up to the plate to try to solve a very difficult problem for their States and their citizens. That's something that I think we should be doing at the national level.

Yet while we have the resources to provide quality care for every American, the incentives in our system don't reward the right types of care.

Our medical system is numb to the relationship between cost and result; it's blind to the need to pay for prevention; and it's deaf to the need to reward good corporate citizens who provide decent coverage for their workers.

We're not getting our money's worth for our health care dollars. We spend in this country more per person than any nation in the world. Yet according to the Commonwealth Foundation, our healthy life expectancy is tied for last among 33 industrialized countries. More than 46 million Americans don't have any health insurance at all—including over 9 million children. And if our health care spending continues to rise at current rates, we'll be putting one-third of our GDP into health care costs by the year 2040.

Our payment system is upside-down: too often paying for costly and debilitating treatment but not for low-cost prevention.

The *New York Times* ran a series on diabetes that spelled it out as clearly as I've ever seen it in the media. Our system will pay tens of thousands of dollars for a diabetic's amputation, but not a low-cost visit to a podiatrist that could have saved someone's feet, and I'll be introducing diabetes legislation later this month that

will address several of the issues raised by this *New York Times* series.

The market now rewards businesses that unload health care costs onto their employees, onto other employers, and onto local, State, and Federal Government programs, while basically punishing companies that try to do the right thing.

The deck is stacked against good corporate citizens who provide decent coverage. Not only do responsible companies carry the health care expense for their workers, they often pay for coverage of their dependents whose own employers don't provide health insurance.

Small businesses are particularly impacted by these high costs of coverage, and we need to be looking for ways to help them.

I was pleased to join with Senator Durbin and Senator Lincoln last year to introduce legislation that would help small businesses provide coverage through a mechanism modeled after the Federal Employee Health Benefits Program, and I think that this model is one step of many we can take to improve access to quality coverage.

Our country has never been about racing to the bottom, never been about ignoring evidence and going with ideology over fact. The private sector and public sector can and must work together to craft a uniquely American solution.

We need to develop a health care system that reflects and responds to how people are living today—that does incentivize people to take better care of themselves, but doesn't leave them on their own.

I believe we can solve our Nation's health coverage crisis, and I look forward to working with my colleagues on this committee to help ensure Americans have quality, affordable health care.

Thank you.

Prepared Statement of Senator Obama

Mr. Chairman, I join my colleagues in commending you for kicking off this new Congress by organizing a roundtable on what is arguably the No. 1 health issue facing Americans today—the rising cost of health care. This is not a new issue, and health care experts, including many in this room today, have been examining and debating this issue for decades.

Nevertheless, real efforts to tackle this problem on a national level have been stymied by politics and a lack of collective will. As a result, we're now facing a true crisis, and we're paying a steep price for Federal inaction.

We all know the statistics about the rate at which premiums are increasing, and the percentage of people who have to declare bankruptcy for medical reasons.

We know about the large number of uninsured Americans who face significantly worse health outcomes because of delayed or foregone care. We know how these costs are ultimately borne by public programs and through higher premiums for people with health insurance. And we know how our health insurance crisis affects hospitals and small businesses.

So, we know what the problem is. And we actually know pretty well what some of the solutions are.

Patients with chronic illnesses account for 75 percent of all health care spending. For that reason, we need to develop a nationwide chronic care delivery system for the chronically ill that would ensure that every patient has a regular doctor who can help to coordinate care and provide access to disease management programs, all of which can improve health and dramatically reduce costs.

Even more important is promoting healthier lifestyles in children and adults, which can prevent or delay the onset of many chronic diseases.

The rate of obesity among adults has doubled in the last 20 years, with almost one-third of adults now being affected. Obesity increases the risk for a number of chronic diseases, including diabetes, heart disease, arthritis and some cancers. This doubling of the obesity rate accounts for nearly 30 percent of the growth in the cost of private insurance. And yet, the Federal Government only spends pennies of every health dollar on prevention activities.

Finally, we know that up to 30 cents of every health care dollar is spent on administration and overhead as opposed to direct clinical care. Even just moving to electronic claim adjudication alone could save the United States about $5 billion per year.

In the last Congress, I introduced legislation to address some of these issues, including health care quality and prevention, and I will continue to focus on each of these areas in this new Congress. Improvements in each of these areas will certainly lead to substantial cost savings in the long-term, but they will not completely address the immediate crisis at hand.

For all the national attention and acknowledgement of these issues, the Federal Government and the Congress have not stepped up to the plate and implemented meaningful, comprehensive reform. Fortunately, the States and the private sector have acted. In recent years, many health plans and self-insured employers have aggressively started tackling cost-containment. States, like Illinois, have championed innovation and intervention to expand coverage and improve quality.

But ultimately, we're going to need Federal intervention, so I look forward to hearing more today about State experiments and public and private sector initiatives that could help us as we begin work to develop a national strategy to address costs and expand coverage. Thank you.

PREPARED STATEMENT OF THE AMERICAN COLLEGE OF PHYSICIANS (ACP)

The American College of Physicians (ACP)—representing 120,000 physicians of internal medicine and medical student members—is the largest physician specialty organization in the United States. On behalf of its members, ACP is releasing sweeping new policy recommendations to reform Medicare, Medicaid, SCHIP, and other programs supported by the Federal Government to advance patient-centered primary care. Patient-centered primary care is a model of health care delivery that has been proven to result in better quality, more efficient use of resources, reduced utilization, and higher patient satisfaction.

Patient-centered primary care will facilitate the ability of physicians, working in partnership with their patients, to implement a systems-based approach to delivering patient-centered services that have been shown to result in better quality, lower costs, and higher patient satisfaction. It will also avert an impending collapse of primary care medicine by restructuring payment policies to support the value of care provided by a primary care physician. Moreover, patient-centered primary care will extend the benefits of a patient-centered health care system to all Americans by taking immediate steps toward making affordable coverage available to the unin-

sured and by giving them direct access to patient-centered health care through a medical home.

ACP's recommendations acknowledge that the State of America's health care in 2007 is inadequate and that comprehensive reforms are needed to determine how medical care is organized, valued, financed and reimbursed.

America's health care system is inadequate in the following ways: (1) According to most recent estimates by the U.S. Census, almost 47 million Americans do not have health insurance coverage.[1] The United States is the only major industrialized nation in the world that does not provide health insurance coverage to all of its citizens; (2) The uninsured are less likely to have access to regular care by a personal physician, less likely to receive needed and recommended preventative services and medications, and are more likely to succumb to preventable illnesses, more likely to suffer complications from those illnesses, and more likely to die prematurely[2]; (3) Per capita health care expenses are considerably higher in the United States, and consume a higher proportion of the national Gross Domestic Product (GDP) than other industrialized nations[3]; (4) Americans receive preventative and other health care less than half of the times recommended by evidence-based guidelines[4] and often receive health care that is unnecessary, excessive, and possibly even harmful[5]; (5) The United States has a much lower proportion of primary care physicians to specialists than other industrialized nations that score better on measures of cost and quality; pays more for procedures provided by specialists than for evaluation and management services provided by primary care physicians; and enables huge earnings inequities that favor procedural specialists over primary care[6]; (6) This imbalance between specialty and primary care exists even though dozens of studies show that the availability of patient-centered primary care is positively and consistently associated with better quality, reduced mortality, higher patient satisfaction and lower costs of care.[7]

The problem in primary care is consistently getting worse: as ACP reported in January 2006 in its State of the Nation's Health Care report, the U.S. health care system is facing a collapse of primary care medicine. Very few new physicians are going into primary care and many of those currently in practice are leaving the field or are planning to retire in the near future. These changes are occurring at the same time that demographic trends—an aging population with more chronic conditions—will require more primary care physicians. The result of this collapse of primary care will be higher costs, lower quality, diminished access, and decreased patient satisfaction.[8]

ACP proposes a solution to such inadequacies that would redirect Federal health care policy toward supporting patient-centered health care that builds upon the relationship between patients and their primary and principal care physicians and supports the systems needed to achieve better results. This would involve applying systems-based models that have been proven to work in other nations' health systems (adapting them to the unique circumstances and needs of the United States) and in successful patient-centered health programs within the United States.

A patient-centered health care system is one that provides continuous access to a personal primary or principal care physician who accepts responsibility for treating and managing care for the *whole* patient through an advanced medical home (AMH), also known as a patient-centered medical home rather than limiting practice to a single disease condition, organ system, or procedure. A patient-centered health care system also supports the specific characteristics or care that evidence shows results in the best possible outcomes for patients. It recognizes the importance of implementing systems-based approaches that will enable physicians and other clinicians to manage care, in partnership with their patients, and to engage in contin-

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[1] U.S. Census Bureau. Health Insurance Coverage 2005. Accessed at *http://www.census.gov/hhes/www/hlthins/hlthin05/hlth05asc.html.*

[2] Institute of Medicine, *Care Without Coverage: Too Little, Too Late*, National Academy Press, 2002.

[3] Reinhardt U, Hussey P, Anderson G. *U.S. Health Care Spending in an International Context.* Health Affairs 2004;23(3): 12–25.

[4] McGlynn, EA, et al. *The Quality of Health Care Delivered to Adults in the United States.* NEJM 2003; 348:2635–2645.

[5] Fisher, E, et al. *Avoiding the Unintended Consequences of Growth in Medical Care: How Might More be Worse?*, Journal of the American Medical Association, February 3, 1999; Vol 281, No. 5.

[6] Starfield B. Shi L, and Macinko J., *Contributions of Primary Care to Health Systems and Health*, Millbank Quarterly, 2005;83:457-502.

[7] Barbara Starfield, *The Primary Solution*, Boston Review, November/December 2005, *http://bostonreview.net/BR30.6/starfield.html.*

[8] Thomas Bodenheimer, MD, *Primary Care—Will it Survive?*, New England Journal of Medicine, 355;9,August 31, 2006.

uous quality improvement. At the same time, a patient-centered health care system will introduce transparency in consumer decisionmaking and accountability for getting better results. Moreover, this system will create a new financing, reimbursement, and delivery models that support the ability of physicians and patients to provide and receive patient-centered care. Finally, a patient-centered health care system will assure that all individuals will have access to care through a patient-centered medical home (PC-MH) by providing affordable health insurance coverage to all and creating models that will provide everyone with the option of receiving care through a PC-MH.

More specifically, the Commonwealth Fund has suggested that patient-centered primary care should have most of the following characteristics:

(1) Superb access to care including ease of making an appointment and e-mail and telephone visits when they are an appropriate substitute for in-person care and electronic prescription refills.

(2) Patient engagement in care: option for patients to be informed and engaged partners in their care, including a recasting of clinician roles as advisers, with patients or designated surrogates for incapacitated patients serving as the locus of decisionmaking (when desired by patients); information for patients on conditions, treatment options, and treatment plans; clear delineation of roles and responsibilities for patients, caretakers, and clinicians; patients reminders and alerts for routine preventative care or when special followup is necessary.

(3) Clinical information systems that support high-quality care, practice-based learning, and quality improvement: registries; monitoring adherence; ease of access to laboratory and diagnostic test results; physicians and patient reminders or alerts; decision support for physicians and patients; information on recommended treatment plans; and longitudinal charts on risk factors, use of services, and outcomes.

(4) Care coordination: coordination of specialist care, including systems that monitor whether recommended referrals take place; prompt feedback of specialist consultation reports to primary care physicians and patients; information about the availability and quality of specialty services and community resources; systems to prevent errors that occur when multiple physicians or sites are involved in care; post-hospital followup and support; tracking of tests, test results, procedures, and the filling of prescriptions to monitor patient adherence to mutually agreed-upon diagnostic and treatment plans; and communication among health care providers who care for a patient, but do so in different geographic locations or at different times.

(5) Integrated, comprehensive care and smooth information transfer across a fixed or virtual team of providers: including physicians, advanced practice nurses, nurses, and others as needed (i.e. social workers, nutritionists, health educators, exercise physiologists, and behavioral health specialists), and elimination of information and testing.

(6) Ongoing and routine patient feedback to a practice: using, for example, low-cost, internet-based, patient-centered care surveys, leading to targeted plans for practice improvement. Such surveys following a patient encounter or episode of care could be used by the physician or practice to understand what went right or wrong from the perspective of the patient and suggest opportunities for improvement.

(7) Publicly available information on practices; information by which a patient could choose a physician or practice most likely to meet the patient's needs.[9]

Many U.S. physicians already are providing some of the characteristics of patient-centered care, but few provide all of them.[10] In comparison, many other industrialized countries have made a deliberate policy decision to build their health care systems around patient-centered care, and physicians in those countries are far more likely to report that they have all or most of the characteristics associated with patient-centered care.[11]

A principal reason why the United States does not consistently deliver patient-centered care is that payment systems used by the Centers for Medicaid and Medicare Services (CMS) and most private payers reward physicians for the volume of procedures generated and the number of office visits performed, rather than for ongoing continuous and longitudinal management of the patients' whole health, supported by systems-based practice improvements that lead to better results.

There is substantial and growing evidence that a health care system built upon a foundation of patient-centered primary care will improve outcomes, result in more

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[9] Davis, Karen, Schoenbaum, Stephen C. & Audet, Anne-Marie. *A 2020 Vision of Patient-Centered Primary Care.* Journal of General Internal Medicine 2005;20:953–957.

[10] Audet, Anne-Marie, Davis, Karen, & Schoenbaum, Stephen C. *Adoption of Patient-Centered Care Practices by Physicians.* Archives of Internal Medicine. 2006;166:754–759.

[11] Schoen C, Osbern R, et al. *On the Front Lines: Primary Care Office System's, Experiences and Views in 7 Countries.* Health Affairs 2006;25:w555–w571.

efficient use of resources, and accelerate systems-based improvements in physician practices. According to an analysis by the Center for Evaluative Clinical Sciences at Dartmouth, States that have relied more on primary care have lower Medicare spending (inpatient reimbursements and Part B payments), lower resource inputs, lower utilization rates, and better quality of care.

Starfield's review of dozens of studies on primary-care oriented health systems found that primary care is consistently associated with better health outcomes, lower costs, and greater equity in care. Primary-care oriented countries such as Australia, Canada, New Zealand, and the United Kingdom rate higher than the United States on many aspects of care, including the public's view of the health care system not needing completely rebuilding, finding that physicians' advice is helpful, and coordination of care. "The United States rates the poorest on all aspects of experienced care, including access, person-focused care over time, unnecessary tests, polypharmacy, adverse effects, and rating of medical care received." However, in the United States, adults with a primary care physician rather than a specialist, had 33 percent lower cost of care and 19 percent less likely to die. It is important to also note that the supply of primary care physicians is consistently associated with improved health outcomes for conditions like cancer, heart disease, stroke, infant mortality, low-birth weight, life expectancy, and self-rated care. In both England and the United States, each additional primary care physician per 10,000 people is associated with a decrease in mortality rates of 3 to 10 percent. Specifically in the United States, an increase of one primary care physician is associated with 1.44 fewer deaths per 10,000 people, and the association of primary care with decreased mortality is greater in the African American population than in the white population.[12]

Another analysis found that when care is managed effectively in the ambulatory setting by primary care physicians, patients with chronic diseases like diabetes, congestive heart failure, and adult asthma have fewer complications thus leading to fewer avoidable hospitalizations.[13]

Patient-centered primary care will also accelerate the transformation of physician practices by making the business case for physicians, including those in small practice settings, to acquire and implement health information technologies and other systems-based improvements that contribute to better outcomes. Yet authors of a recent survey found that a "gap exists between knowledge and practice—between physicians' endorsement of patient-centered care and their adoption of practices to promote it. Physicians reported several barriers to their adoption of patient-centered practices, including lack of training and knowledge and costs. Education, professional and technical assistance, and financial incentives might facilitate broader adoption of patient-centered care practices. With the right knowledge, tools, and practice environment, and in partnership with their patients, physicians should be well positioned to provide the services and care that their patients want and have the right to expect."[14]

In ACP's new position paper, *"A System in Need of Change: Restructuring Payment Policies to Support Patient-Centered Care,"* the College proposes that the Federal Government take the lead in restructuring payment policies to achieve patient-centered health care. The College's recommendations would transition Medicare from paying doctors solely on the number of procedures or visits generated to paying them for providing patient-centered health care. The College also proposes a pathway for eliminating automatic cuts in payments generated by the flawed Sustainable Growth Rate, or SGR, formula, because continued SGR payment cuts will make it impossible for physicians to invest the resources in the systems required to provide patient-centered care, accelerate the collapse of primary care medicine and result in severe limitations on access to care for Medicare beneficiaries. ACP proposes the following payment reforms to support patient-centered care:

1. Institute a multi-component payment structure that facilitates more effective and efficient care delivery for patients through the Patient-Centered Medical Home that would include:

• A *bundled and prospective payment* component that would include all of the physician work associated with coordinating care that is not included in payments for face-to-face visits, such as arranging care with other health professionals and family-caregivers and following up with patients on self-management plans. *Bundled* means that the payment would include a defined package of services related

[12] Starfield, presentation to The Commonwealth Fund, Primary Care Roundtable: *Strengthening Adult Primary Care: Models and Policy Options*, October 3, 2006.

[13] Commonwealth Fund, Chartbook on Medicare, 2006.

[14] Commonwealth Fund study, *"Adoption of Patient-Centered Care Practices by Physicians: Results from a National Survey"* (*Archives of Internal Medicine*, April 10, 2006).

to care coordination rather than billing for such services on an a la carte basis. *Prospective* means that the payment would be made on a regularly scheduled timetable, such as monthly, for each patient who receives care in the patient-centered medical home without necessitating that the physician generate a bill for a specific procedure or visit.

• *A bundled and prospective payment component that provides sustained funding for the systems* needed for a physician practice to deliver patient-centered care, such as patient-registry systems, evidence-based clinical decision support at the point of care, computerized order entry and e-prescribing systems, secure e-mail, and electronic health records that have the functionalities required to provide patient-centered care.

• *Risk-adjustment* of the prospective bundled payment to account for differences in the health status, disease conditions, chronic illnesses, and severity of illness of the patient population seen by physicians in a patient-centered medical home.

• *A fee-for-service visit* component that would allow physicians to continue to bill for face-to-face encounters with patients.

• *A performance-based* component that provides additional bonus payments based on reporting of evidence-based quality, cost of care, and patient satisfaction measures.

This payment structure would:

• Recognize the value of the time and work required of physicians and their staffs to manage and coordinate the care of patients, rather than paying them only for the work involved in providing a face-to-face visit or procedure.

• Accelerate practice transformation by providing sustained funding to support the ability of physicians to acquire and use health information technology and other systems-based tools needed to provide patient-centered care; such expenses are not currently supported by Medicare payment policies.

• Be risk-adjusted to create a strong incentive for physicians to accept responsibility for providing patient-centered care to patients' with multiple chronic illnesses.

• Combine the prospective payment structure with fee-for-service payments for face-to-face visits to assure that physicians will continue to see patients in their offices, unlike traditional capitation models that created disincentives for physicians to see patients. This "hybrid" system of prospective bundled payment and FFS payments has been implemented successfully in countries like Denmark that have patient-centered health care systems.[15]

The following example illustrates how ACP's new bundles payment structure would work in an internal medicine practice:

• Dr. Smith is an internist in a four-person internal medicine practice in Des Moines, Iowa. Her practice has demonstrated, through an independent review process, the necessary characteristics required to be qualified as a patient-centered medical home. To assist the physicians in providing patient-centered care, the practice recently implemented a software patient registry program to allow them to rack the care provided to patients by medical condition. It also has established a secure e-mail consultation service that generates "reminders," based on evidence-based guidelines, on steps that patients can take to improve or maintain their own health as part of an integrated self-management plan that Dr. Smith developed in partnership with each patient.

• Fifty percent of the practice's patients are Medicare enrollees who have selected the practice as their medical home, and 10 percent of those patients have four or more chronic conditions, like diabetes, congestive heart failure, and asthma. Medicare would pay Dr. Smith a baseline monthly "care coordination" payment that includes the value of the time that she and her colleagues spend coordinating care outside of the face-to-face visits. The prospective payment also includes an allowance for the costs incurred by the practice in acquiring and sustaining the patient-registry software and the secure e-mail service. The baseline payment would be increased for those Medicare patients who have multiple chronic diseases.

• The secure e-mail program allows Dr. Smith to communicate with patients after regular hours on non-urgent medical issues, and to generate secured e-mail reminders to them that followup on recommended treatment plans. This reduces the number of times that patients have come into the office to see Dr. Smith and her colleagues. This frees up time so that when patients do need to be seen in her office, Dr. Smith is able to spend more time with them. She bills Medicare on a fee-for-service basis for the office visits using existing codes and relative value units.

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[15] Karen Davis, Ph.D., Stephen C. Schoenbaum, M.D., and Anne-Marie Audet, M.D., *A 2020 Vision of Patient-Centered Primary Care*, Journal of General Internal Medicine, October 2005; 20(10):953–957.

• Dr. Smith's practice also regularly reports on its performance using evidence-based measures for primary care that have been approved by the National Quality Forum and the AQA, multi-stakeholder bodies that respectively endorse and implement quality measures based on criteria that have been broadly accepted by physicians, health plans, employers, and consumers. At the end of the calendar year, Dr. Smith's practice receives a Medicare bonus payment based on excellent performance and measures.

2. Make changes within the resource-based relative value scale (RBRVS) system to improve accuracy of work and practice expense relative values, support physician-directed care coordination, provide an incentive for the adoption of health information technology linked to quality improvement efforts, and provide incentives for physicians to participate in programs to continuously improve, measure and report on the quality and cost of the care provided. Medicare should specifically allow for separate "care coordination" procedure codes and relative value units that would allow physicians in practices that have not been recognized as qualified patient-centered medical homes to bill for care coordination on a retrospective, fee-for-service basis with appropriate documentation of the work involved.

3. Enact legislation to provide an "add on" to the Medicare office visit fee for small physician practices when it is supported by a certified electronic health record that has the functional capabilities needed to provide patient-centered care and to measure and report on the quality of care provided, as proposed in bipartisan legislation introduced in the 109th Congress called the National Health Information Incentive Act. (This "add on" would not apply to physician practices that qualify as patient-centered medical homes because such practices would be reimbursed on a prospective basis for the systems improvements needed to deliver patient-centered care).

4. Replace the Sustainable Growth Rate (SGR) Formula with a new methodology that will provide positive and predictable baseline payments and create powerful incentives for physicians to design, implement and participate in programs to improve quality and achieve more efficient use of resources:

• The College proposes a transitional pathway to eliminate the SGR that will culminate in a stable and predictable methodology for updating physician payments and create a strong incentive for physicians to participate voluntarily in a Medicare pay-for-reporting program. During the transition period, changes would be made in the transitional pay-for-reporting program now being instituted by Medicare to provide greater bonus payments to physicians who acquire the systems needed to deliver patient-centered care and who do more to improve quality, rather than a "one-size-fits-all" program that pays all physicians the same amount for reporting a few measures, regardless of the impact of those measures on improving patient care.

• At the end of the transition, the SGR would be replaced with a new update system that would have three components:

- A baseline physician payment update that takes into account the costs of delivering care, beneficiary access to services, workforce and other data on trends that may affect access and quality.
- A separate pool of funds that would be set aside to fund qualified physicians' quality improvement programs that have the greatest potential to achieve quality improvements and cost efficiencies for the Medicare population, including programs that are designed to support patient-centered care.
  - Performance payments to physicians would be paid on a weighted basis to physicians who agree to participate in the quality improvement programs funded by the pool.
  - This physician payment quality improvement pool would be funded in part by systemwide Medicare savings that are attributable to quality improvement programs funded out of the pool. For example, the pool could fund programs that reward physicians for helping to keep patients with multiple chronic diseases out of the hospital. A portion of Medicare Part A savings would then be redistributed back into the physician performance pool.
  - "Weighted" payments mean that physicians who successfully participate in programs that have the greatest impact on quality and cost would receive greater bonus payments than those who do not participate, or who participate in programs that will have a lesser impact on quality and cost. This is fundamentally different from the current "one-size-fits-all" transitional Medicare pay-for-reporting program, which will pay physicians the same percentage bonus payment for as few as three measures regardless of the impact of the measures on improving quality and reducing costs.

- A process that would direct the Medicare Payment Advisory Commission to consider making formal recommendations to Congress on discretionary bonus payments to achieve specific policy objectives, such as increasing the supply of primary care physicians.

The benefits of a patient-centered health care system should not be limited only to those who currently have health insurance coverage. The 47 million Americans who now lack health insurance coverage are much less likely to have a regular source of care, never mind having access to physician practices that are organized to provide patient-centered primary care. The College believes that immediate steps must be taken to expand health insurance coverage, with the goal of providing coverage to all Americans. Proposals to expand health insurance coverage should also assure that patients have access to a core set of benefits that includes preventive and primary care services and other services associated with patient-centered care. In addition, proposals to expand coverage should provide funding and incentives to assure that all patients will have access to care through a patient-centered medical home. To accomplish this goal, the College proposes that Congress:

1. Provide dedicated Federal funds to support State-based programs that will reduce the number of uninsured and provide access to services through patient-centered medical homes.

2. Provide waivers to States that wish to redesign their Medicaid and SCHIP programs to give enrollees access to services through a patient-centered medical home including changes in reimbursement policy to support PC-MHs.

3. Enact Federal legislation to implement a step-by-step plan to provide health insurance coverage to all Americans by a defined date through changes in Federal entitlement programs, tax credits and other subsidies to allow low-income working Americans to buy into the Federal Employees Health Benefit Program, and insurance market reforms.

Translating the College's proposals for redesigning American health into action will require Congress, the Centers for Medicare and Medicaid Services, employers, and health plans to take immediate steps to create pathways for building and implementing patient-centered changes through U.S. health care. The Federal Government has a particular responsibility to use its enormous purchasing authority to drive the systems changes needed to support patient-centered care.

ACP's policy proposal for implementation of legislative action to accelerate and advance patient-centered care would include the following:

1. Expanding the new Medicare demonstration of patient-centered care.

2. Redesigning the voluntary Medicare physician pay-for-reporting program to emphasize systems-based approaches to delivering patient-centered care and to vary payments based on the impact of the systems and processes being measured and the practice expenses associated with obtaining the tools required.

3. Creating additional reimbursement incentives for physician-directed care coordination and systems improvements that lead to better care.

4. Replacing the SGR with a new payment methodology that would provide predictable and positive baseline payments, emphasize systems-based approaches to improving quality and reducing costs, provide dedicated funding for quality improvement programs that will have the greatest impact on quality and cost, and allow physicians to share in non-Part B program savings associated with better care management in the ambulatory setting.

5. Providing States with dedicated funding and increased flexibility to expand coverage and redesign Medicaid and SCHIP around the patient-centered medical home.

6. Expanding health insurance coverage through a combination of public and private funding resources.

President Bush and the 110th Congress have an historic opportunity to join with the College, other physician organizations, employers, and health plans to redesign the American health care system to deliver the care that patients need and want, to recognize the value of care that is managed by a patients' personal physician, to support the value of primary care medicine in improving outcomes, and to create the systems needed to help physicians deliver the best possible care to patients. The College's policy recommendations and implementation roadmap are offered as a comprehensive plan for achieving a high quality, affordable, and patient-centered health care system for all Americans.

[Whereupon, at 12 p.m., the hearing was adjourned.]

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